The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
Eileen Elias, Commissioner

FISCAL YEAR 1994
ADULT & CHILD/ADOLESCENT IMPLEMENTATION REPORT
and
FISCAL YEAR 1995
STATE MENTAL HEALTH PLAN

December 1994

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
Eileen Elias, Commissioner

1995 Community Mental Health Services Block Grant Application

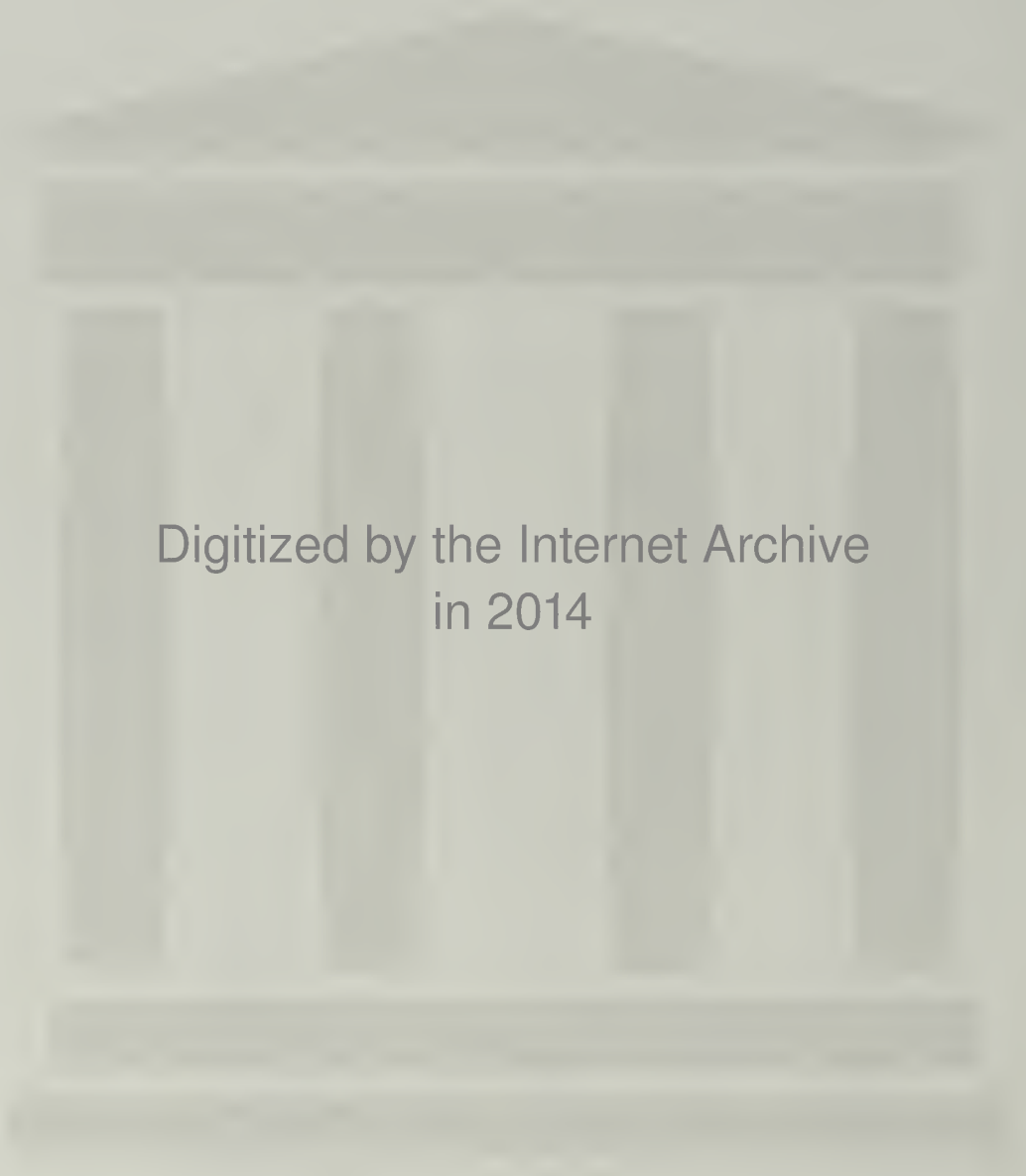
(P.L. 102-321)

including:

* **1994 Adult and Child/Adolescent Implementation and Expenditure Report**

* **1995 State Mental Health Plan**

December 31, 1994



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EXECUTIVE SUMMARY

The 1995 Block Grant Application includes the 1995 State Plan, a report from the Mental Health Planning Council and an Implementation Report on the goals, objectives and expenditures in the 1994 State Plan. During the past year, the Department of Mental Health continued the redesign of its service delivery system to create a system of Public Managed Care, based on the establishment of Comprehensive Community Support Systems (CCSSs) that assure access, quality and cost-effectiveness of mental health services. Each CCSS represents a consumer-centered mix of state and private provider-operated services located in one of the Department's 33 natural service areas, grouped within seven DMH Areas. As the basis for Public Managed Care, a CCSS provides a continuum of mental health and rehabilitation services that are flexible and responsive to the individual needs and preferences of adult consumers and of children, adolescents and their families. Each DMH Area is continuing to develop an array of mental health services linked to a network of generic and informal community supports to enable adults and children to live in their home communities despite severe disabilities.

The goals and objectives in the 1994 State Plan formed the basis of CCSS multi-year plans for each of the Department's natural service areas. Highlights of Fiscal Year 1994 accomplishments are: savings derived from the closing of the Gaebler Children's Center were used to fund one continuing care inpatient unit and two Clinical Intensive Residential Treatment programs for young children; policies regarding Smoking, AIDS/HIV+, Standards of Care, Mandatory Forensic Reviews and Review of Criminal Records for DMH and Vendor Employees were developed; Utilization Management standards as well as standards for crisis, day, evening, and other programs were developed and approved; and a task force met intensively to develop a new way of contracting for adult and child/adolescent residential services in an effort to provide as much flexibility as possible in meeting consumers' individual needs and preferences. In addition, the Department's citizen advisory boards were reorganized, and new members appointed. Consumers and other interested stakeholders continued to be involved in DMH planning activities at all levels and advocates met regularly to discuss and take action on national issues pertaining to health care reform.

In SFY'95, DMH expects to implement the single residential code for contracts awarded in SFY'96 and continue its review of the DMH enabling statute to ensure that it appropriately reflects DMH's role in a reconfigured health care system. The infrastructure for the quality and utilization management systems will be strengthened, standards of care and performance indicators for the rest of the Department's programs completed, the Client Registration and Enrollment System further developed and the core curriculum will continue to be taught to adult and child providers. Finally, there will be continued focus on service and fiscal integration with Medicaid's mental health and substance abuse managed care program and on developing an interagency seamless system of care for children and adolescents.

The Mental Health Planning Council continues to monitor implementation of goals and objectives and approved the workplan for 1995. The Council's subcommittee on the mental health needs of elders produced recommendations that will be acted on by DMH in SFY'95. A pilot project was initiated in SFY'94, to continue in SFY'95, that addresses some of the unmet mental health needs of elders through a series of training conferences for professionals and senior advocates. The Multi-Cultural Advisory Committee held a conference on multicultural treatment and systems integration issues for professionals, consumers and family members of color.

The 1995 Plan documents maintenance of effort in spending for community services, including children's services, and provides a spending plan for FFY'95, even though the final amount of the federal allocation is uncertain (as of the time of its submission to the Center for Mental Health Services on October 1, 1994). The Department will use block grant funds to address service gaps identified through the CCSS planning process, furthering the Department's ability to ensure a public managed care system based on an organized system of care.

STATE MENTAL HEALTH PLANNING COUNCIL

The State Mental Health Planning Council was established under P.L.99-660 as a standing committee of the Statewide Advisory Council (SAC) to the Massachusetts Department of Mental Health. The SAC is established by statute (MGL c.19, section 11) and regulation (104 CMR 2.16 [5]) and consists of 15 individuals appointed by the Secretary of the Executive Office of Health and Human Services to "advise the commissioner on policy, program development and the priorities of need in the Commonwealth for comprehensive programs in mental health." All members of the Planning Council are nominated and appointed by SAC and represent consumers, family members, legal advocates, providers, other state agencies, mental health professionals and professional organizations, legislators and state employee unions. Membership includes family members of adults and children and members of cultural and linguistic minority groups. The Department provides staff to the Council.

Initially the Council appointed six subcommittees from among its own members and other interested individuals to address what were identified as the main issues in writing a comprehensive state mental health plan under P.L.99-660. The subcommittees were: **Adult Services**, **Child/Adolescent Services**, **Legal/Human Rights**, **Human Resources**, **Finance** and **Minority Access**. Their work was instrumental in producing the Comprehensive Mental Health Service Plan issued in May 1991 and revised in September 1991. For the most part, the subcommittees were dissolved when the Plan was completed. The Council was reorganized in 1992 and new members were nominated and appointed by SAC. (It should be noted that many members of the Planning Council also have been actively involved in the Department's Comprehensive Community Support System participatory planning process, initiated in 1991 and described in much detail in the 1993 Implementation Report.) There are currently three subcommittees, with membership that includes individuals on the Planning Council as well as other interested persons. These subcommittees address issues concerning the mental health needs of: **elders**, **children and adolescents** and **racial and linguistic minority groups** and maintain their own schedules and agendas.

The **Elder Mental Health** subcommittee, for example, has been particularly active in response to concerns about the unmet needs of this segment of DMH's target population. Last year, the subcommittee proposed a set of recommendations regarding the mental health needs of the elderly, to assure their needs are incorporated into the planning and operations of DMH. Also last year, a Request for Proposals was issued for a training program aimed at improving and increasing mental health services for this population, and the Massachusetts Association for Older Americans was subsequently selected to present four training conferences, funded through the federal block grant, for professionals and senior advocates. One conference was held in SFY'94 and the remaining three are scheduled for SFY'95. The subcommittee's

recommendations were reviewed by the Department's Policy and Planning Committee, approved by the Commissioner and will be implemented this year.

The Planning Council meets several times each year to: review the Department's annual goals and objectives (State Plan); receive updates regarding implementation; and address concerns regarding the operations of the Department and/or its programs and policies. It met on December 13, 1993 and September 29, 1994. On September 29, the Council reviewed and approved the 1995 State Plan. Their letter to the Commissioner concerning the Plan is included at the end of this document.

Members of the State Mental Health Planning Council, their affiliations and areas of special interest and expertise are:

STATEWIDE MENTAL HEALTH PLANNING COUNCIL

State Employees

Elizabeth Irvin	Dept. of Mental Health	Special Populations
Joan Mikula	Dept. of Mental Health	Children
Marlene Tarpley	Dept. of Mental Health	Multi-Cultural
Steve Holochuck	Dept. of Mental Health	OCER/Consumer
Lisa Zeig	Department of Education	Children
Tom McCarthy	Mass. Rehab. Commission	
Barbara Chandler	Develop. Disabilities Council	
Judge Maurice Richardson	State Judiciary	
Jane Gumble	Exec. Off. Commun. & Develop.	Housing
Ellen Birchander	Exec. Office of Elder Affairs	Elders
James Michel	Div. of Med. Assistance/Medicaid	
Judy Thiffault	Dept. of Mental Health	OCER/Consumer
John Farley	Department of Social Services	Children

Providers

Bernard J. Carey, Jr.	Mass. Assoc. for Mental Health	Housing
Dennis McCrory, M.D.	Consultant	Psych. Rehab.
Kathy Zadig	Westfield Area MHC	Children
Dennis Goldsmith	United Homes for Children	Children/Multicultural
Marjorie Cohan	Northern Berkshire MHC	
Judi Chamberlin	Ruby Rogers Center	Provider/Consumer
Marta Frank	Boston Senior Home Care	Elders
Linda Sacenti	Eastern Middlesex MHC	Provider/Consumer
Henry East-True	Gandara Center	Multicultural
Vacant	Mass. Shelter Providers Assoc.	
Mary Gregorio	Mass. Assoc. of Social Clubs	
Mary Adams	Mental Health Management of America	Medicaid Vendor
Tom Lorello	Tri-City MHC	Homeless Mentally Ill
Sandra Epstein	Vinfen Corp.	Provider/Consumer

Advocates/Professional Organizations

Dorothy Mooney	Mass. Psychiatric Society
Sharon O'Meara	Mass. Psychological Assoc.
Richard Sherman	Mass. Assoc. of Social Workers
Susan Villani, M.D.	New Eng. Council of Child/ Adolescent Psychiatry
Edith Barrett	N.U.R.S.

Ruth Robinson	Statewide Advisory Council	Elders
Gailanne Reeh	Arbour Associates	Children
Jan Falk	Mass. Alliance for Mentally Ill	
Bob Fleischner	Ctr. for Public Representation	Legal/Human Rights
Gil Deford	Mental Health Legal Advisors.	Legal/Human Rights
Rep. Paul Kollios	Committee on Human Services & Elders Affairs	Legislator
Sen. Therese Murray	Committee on Human Services & Elder Affairs	Legislator
Cliff Cohn	SEIU	State Emp. Union
Joel Corcoran	Clubhouse Coalition	
Mike Demers	The Genesis Club	Employmt & Training

Consumers

Betty Francis	A.A.R.P.	Elders
Deborah Anderson	M*Power	
Christopher Dingle	Consumer Advisory Council	Adolescent
Peter Foulkes	The Genesis Club	
Phil Dooley	Baybridge Clubhouse	
Paul Menard	Highland House	
Debbie Stewart	Baybridge Clubhouse	
Lynne Lynn	Alliance for the Mentally Ill	DMH Area Board

Family Members

Trude Lawrence	Alliance for Mentally Ill	Adult
June Gross	Parent Professional Adv. Comm.	Child
Winthrop Alden	Alliance for Mentally Ill	Adult
Sandy Iserman	Statewide Advisory Council	Child
Marion Butler	DMH Parent Coordinator	Child
Marilyn Simon		Child
Judy Frost	Area CCSS Planning Committee	Child
Richard Hogarty, Ph.D.	UMass/Boston:McCormack Institute	Adult
James McDonald	Statewide Advisory Council	Adult
Mary Doyle		Child

THE MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH: A DESCRIPTION

Introduction

Massachusetts is a small industrial state of 6,016,425 people. The per capita income is $17,224 (1990 census). Although some areas of the state are less populated than others, almost every town is attached to an identified urban center. The majority of the population is white although there have been significant increases in racial, cultural and linguistic minorities, including immigrants and refugees from Southeast Asia, Central America, the Caribbean Islands and the former Soviet Union. The history of mental health care reform in Massachusetts includes a number of legislative and executive actions that have cumulatively and dramatically combined to reshape today's mental health system, a system that has grown and changed since 1965, when the legislature created a community (area) based system for those with mental illness and mental retardation.

The process to increase the availability and quality of community programs was enhanced in 1978 when the Brewster consent decree was initiated in western Massachusetts. The consent decree, the result of a joint planning process between the Massachusetts Association for Mental Health, the Massachusetts Association for Retarded Citizens and the Department of Mental Health (DMH), asserted the right of mentally disabled persons in the Western Massachusetts Area to receive care in the least restrictive setting. It signalled a shift in the locus of treatment from institutional to community settings and aimed to reduce the Northampton State Hospital census. As a result, significant resources were directed to this Area to implement the decree, accomplished through contracts with local providers. The Department was disengaged from the consent decree in 1992. In 1984, Executive Order 244 prohibited children and adolescents from being treated on adult inpatient wards of state hospitals and led to the privatization of most care for children under age 19.

The Governor's Special Message in 1985 expanded case management and emergency services and sought funding from the legislature to upgrade and adequately staff the state hospitals and create 2,500 new housing units for adults awaiting community placement. A $340 million Capital Plan that passed the legislature in 1987 promised those funds. Meanwhile, Chapter 599 (Acts of 1986) split the DMH into separate departments of mental health and mental retardation, effective July 1, 1988. This legislation also created a new mission for DMH to "provide for services to citizens with long term or serious mental illness, early and ongoing treatment for mental illness and research into the causes of mental illness." In 1989, a lengthy and inclusive process involving consumers, family members, advocates and mental health professionals produced a new DMH policy on priority consumers that further defined the Department's mission and targeted service population. Severe budget cuts in SFYs'90 and '91, however, impeded progress toward fully implementing the

community housing initiative. In January 1991, the new governor appointed a Special Commission on Consolidation of Health and Human Services Institutional Facilities. The report of the Commission, in June 1991, and the simultaneous arrival of a new mental health commissioner, have been the catalysts for major changes.

A New Vision

Since June 1991, the Department has made significant progress in achieving the vision of a truly comprehensive, community based system of care through implementation of its Public Managed Care initiative, based on the establishment of Comprehensive Community Support Systems (CCSS). This has occurred through a restructuring of DMH, at the central, Area and local levels, to ensure the most efficient use of resources for priority consumers. Their needs, as well as the identification of available resources and gaps, were articulated through a statewide needs assessment and a local, participatory planning process based on standards established to direct and monitor the CCSS planning. As part of the ongoing comprehensive planning process last year, Areas were asked to identify gaps in services and to prepare plans for SFY'95, including budget requirements, to address those gaps. Among the significant achievements in SFY'94: savings derived from the closing of the Gaebler Children's Center were used to fund one continuing care inpatient unit and two Clinical Intensive Residential Treatment programs for young children; the Inpatient Facility Operations Manual (IFOM) was reviewed; policies regarding Smoking, AIDS/HIV+, Standards of Care, Mandatory Forensic Reviews and Review of Criminal Records for DMH and Vendor Employees were developed; Utilization Management standards as well as standards for crisis, day, evening,and other programs were approved. In addition, a task force met intensively to develop a single residential code for adult and child/adolescent residential services in an effort to provide as much flexibility as possible in meeting consumers' individual needs. In SFY'95, DMH expects to finish its work on the IFOM, implement the single residential code for contracts awarded in SFY'96 and continue its review of the DMH enabling statute in anticipation of submitting legislation to reflect DMH's role in a reconfigured health care system. There are also plans to continue building an infrastructure for the quality and utilization management systems and to complete standards of care and performance indicators for the rest of the Department's programs.

Organization of the Department of Mental Health

It is important to note that although Massachusetts does have a county system, the counties do not fund, oversee or provide mental health services. Those responsibilities are primarily those of the state Department of Mental Health. As such, the Department is organized into seven Areas, with each Area office serving as a public managed care entity, managed by an Area Director. Each Area is further divided into natural service areas (CCSSs) - there are 33 statewide - that include state and vendor operated mental health services as

well as generic and other support services available to all citizens. Planning, budget development, program monitoring, most contracting, quality improvement, citizen monitoring and case management emanate from the CCSS and Area levels. The central office of the Department, located in Boston, coordinates planning, sets and monitors attainment of broad policy and standards, develops quality and utilization management systems and performs certain generally applicable fiscal, personnel and legal functions.

Planning for Public Managed Care

Through implementation of Public Managed Care, the Department is currently engaged in the process of changing the way in which mental health and other community based supportive services are provided to DMH priority consumers. Public Managed Care relies on a thoroughly integrated system of care for persons with serious mental illness or severe emotional disturbance and is established on the basic foundation of Comprehensive Community Support Systems (CCSSs). Each CCSS: is consumer-centered; is developed in a local, natural service area; is comprised of critical generic components that encompass five service groups - acute care mental health services, supportive mental health and rehabilitative services, advocacy mental health services, generic community based services and informal/significant other supports; and ensures a single point of clinical accountability for every person in its care. Each CCSS also fosters management of an integrated system, supporting the consumer's movement toward optimal functioning in the least restrictive setting.

The outcome of Public Managed Care is a system in which resources are managed effectively and acute care, the most expensive service, is used only as clinically necessary, allowing the majority of resources to be used to support and expand services for consumers in the community. The resulting services for consumers of all ages promote community integration and prevent unnecessary hospitalization. The primary components of the restructuring process include:

- assuring that each of the seven DMH Area Offices is clinically, fiscally and administratively accountable for each consumer in its care;
- budget support for expanding community based services;
- integration of acute care within the existing health care system;
- consolidation of continuing inpatient care;
- pooling all resources, including DMH, other public and private payers.

Each CCSS (natural service area) has been involved in its own planning activities, under the direction of its Area office, using statewide standards. A key activity was the completion of a major needs assessment for adults. The tool - Resource Associated Functional Level Scale (RAFLS) - is a nationally recognized protocol designed and implemented by Human Services Research

Institute of Cambridge, Massachusetts, to match services needed with the functional levels of consumers (in that area). The final CCSS plans address the needs of adults as well as children, the elderly and selected special and sub-populations. Each CCSS proposed a multi-year plan, which directed SFY'95 budget development and highlighted the need for further restructuring. In some Areas, imbalances in distribution of resources or program types within the Area or CCSS that became evident during the planning process were remedied immediately.

Implementation of Public Managed Care

Implementation of Public Managed Care encompasses a new orientation concerning:

- the emphasis on rehabilitation and recovery rather than exclusively symptom management as the central aim of service delivery;
- how services are integrated to provide community based care;
- how public and private resources are integrated to achieve maximum benefit for consumers;
- expectations regarding the ways in which a public agency manages its fiscal and human resources.

The process of implementation has involved a number of activities. These include:

- the transfer of acute inpatient care from state hospitals to private and general hospitals and, where viable, to 16-bed state-operated community mental health centers;
- the expansion of community programs;
- restructuring the organization at the local level to maximize funding sources and ensure attention to service needs;
- enhancing linkage and continuity of care for consumers in need of mental health services;
- ensuring accountability throughout the system;
- reviewing historic allocations and redistributing resources to meet current needs as identified through CCSS planning.

Closing and Consolidating Facilities

As a result of recommendations in the June 1991 report of the Governor's Special Commission, DMH closed three adult state hospitals - Metropolitan,

Danvers and Northampton - and the Gaebler Children's Center, the only state-operated inpatient facility for children under age 14 in the Commonwealth, between January 1992 and August 1993. As required, all patients in those facilities were transferred or discharged to "equal or better" living situations. DMH "replaced" the inpatient services formerly provided to adults and children in the state hospitals with a variety of innovative and community-oriented programs.

To gauge the success of the hospital closings, which applied the governor's criteria of "equal or better care" for each affected consumer, the Department used a variety of measures. These included: tracking of patients discharged from closed facilities (30 and 90-day follow-up), a review of community service development, financial analysis, outcome studies regarding the success of affected employees at the state facilities in finding employment and progress by DMH in developing and implementing quality assessment and utilization management systems. These activities were documented in two progress reports to the legislature ("Developing a System of Public Managed Care," January 1993 and July 1993). Although there was an initial "shakedown" period after the first acute replacement unit opened - DMH was forced to demand additional security measures and staffing adjustments from the provider - the outcome has been positive, with high consumer satisfaction.

CHALLENGES AND ACHIEVEMENTS

ADULT SYSTEM

Transfer of Acute Care

DMH no longer provides acute care in its state hospitals. Instead, the Department contracts for acute replacement beds in locked psychiatric units that guarantee access to DMH referred patients. Replacement beds are located in general or private psychiatric hospitals and state-operated community mental health centers (CMHCs) across the state under contract to the Department. The contracted beds or units are governed by extensive terms and conditions. In these contracts, DMH pays only for costs not covered by other sources, including private insurance, Medicaid, Medicare and free care. The beds or units are designed to serve those patients whose level of acuity requires more intensive or specialized care than what is available in the general or Medicaid contracted network hospital system.

The Department currently contracts for 177 acute care beds in five general, one municipal and two private psychiatric hospitals, operates 16-bed units at four CMHCs and accepts acute admissions at three other community

mental health centers in the Metro Boston Area, one of which is affiliated with a public health hospital.

Closing the state hospitals and transferring acute care to general and private hospitals or small inpatient units at DMH community mental health centers enabled the Department to eliminate maintenance of antiquated, under-used facilities, maximizes available federal and third party reimbursement, serves consumers who need hospitalization in certified, accredited units closer to home, promotes better integration of psychiatric care with medical needs, provides greater access and opportunities for support by family members and significant others and promotes better coordination with the community service system upon discharge.

In addition, DMH consumers who are Medicaid recipients also have access to an extensive number of acute beds in general and private psychiatric network hospitals throughout the state. These beds operate under contract to Mental Health Management of America, Inc. (MHMA), the private vendor under contract to the Division of Medical Assistance (DMA) to manage its non-HMO mental health and substance abuse Medicaid managed care program. DMH and MHMA use the same (DMH) designated emergency programs to screen patients regarding the need for acute care, and work together to develop and establish uniform clinical standards of care and agreed upon inpatient admission, transfer and discharge criteria and protocols to ensure high quality, appropriate care for DMH consumers regardless of service site or payment source. DMH is continuing to work to expand the use of these criteria and protocols for utilization by health maintenance organizations and other private third party payers to guarantee an enhanced one-tier system of inpatient care, accessible for DMH consumers and locally based.

Consolidation of Continuing and Specialty Inpatient Care

Continuing, rehabilitative and specialty inpatient care (i.e. geriatric, deaf, hard of hearing and forensic) is provided by DMH in a Department of Public Health (DPH) hospital, a municipal hospital (a contracted "replacement" unit in the Western Mass. Area which no longer has a state-operated facility), four remaining state hospitals and in the three state-operated community mental health centers in Boston (one of which is located in a second DPH hospital). The eventual goal for the Metro Boston Area is to consolidate all continuing care into the DPH hospital there.

Centers of Excellence

DMH funds two Research Centers of Excellence, one in Clinical Neuroscience and Neuropharmacology and one in Behavioral and Forensic Sciences. Both centers are conceptualized as Public/Academic Liaisons, a model of interaction for clinical research championed by the Center for Mental Health Services. Both centers are structured interdependently with DMH and with an accredited academic institution, and are expected to collaborate and cooperate with each other through a special DMH governance committee that

supervises and monitors the centers. Both centers are expected to meet mutually agreed upon standards and have contracts that include performance-based outcomes.

Developing Alternative Services

DMH continues to work toward reducing the need for hospitalization by expanding the number of crisis, crisis diversion and respite services available to adults who come through DMH designated emergency programs and by improving integration of acute diversion with community support programs, including collaborating with DMA and its vendor, MHMA, to assure an adequate and coordinated network of appropriate options. Savings derived from decreased reliance on inpatient care are used to increase community services.

In addition, DMH opened 625 new community residential beds between SFY'91 and SFY'92, 249 in SFY'93, including 150 new beds for homeless individuals with serious mental illness, and 368 more in SFY'94, including about 125 new beds for homeless individuals.

CHILD/ADOLESCENT SYSTEM

Reshaping the Inpatient Care System

To replace the Gaebler Children's Center, which formerly served 42 children under the age of 14, DMH contracts for one continuing care inpatient unit of 12 beds and two (regional) residential treatment programs of 10 beds each. These units serve youngsters statewide. The closing of Gaebler also freed $2.2 million for community expansion services, including crisis intervention, hospital diversion, home and school-based treatment, aimed at maintaining and/or reintegrating children with their families where possible. A Gaebler Advisory Committee, including parents and advocates, was instrumental in planning for the replacement services and continues to monitor the development of the new system.

Children who are Medicaid recipients and in need of acute hospitalization receive those services through the MHMA hospital network or health maintenance organizations. Children without insurance are hospitalized under free care arrangements with private psychiatric and general hospitals. In one Area, where there is no private psychiatric hospital, the Area has an allocation for purchasing bed days on an as needed basis. All youngsters admitted for acute hospitalization receive DMH case management assistance with discharge planning. The Department continues to work closely with MHMA to ensure a one tier system of acute care by implementing the jointly developed clinical standards of care, transfer and discharge criteria, to ensure cooperation and continuity of care.

In addition to the new, longer-term beds for younger children, DMH continues to provide continuing inpatient care for adolescents in two state hospital units operated by private vendors.

Child/Adolescent System Planning Goals

The current Area based CCSS planning initiative will chart the future direction for child/adolescent services. The goals of this process include:

- reducing the need for inpatient care through expansion of community based services such as crisis intervention and crisis residences;
- developing clinical standards and a utilization management system for all child and adolescent programs;
- enhancing integration with other child-serving agencies to reduce duplication and create a seamless system of care for children and families;
- inclusion of parents in all aspects of policy development and planning, as well as in the treatment of their children.

THE DMH TARGET POPULATION

The Department considers its "target" or "planning" population to be individuals who are determined, through DMH estimates of prevalence of serious mental illness and severe emotional disturbance, as likely to need or use publicly funded mental health services. Specific numbers are included in the relevant sections of this document. This may include persons already known to DMH and receiving services, individuals (particularly children) who need or receive mental health services from more than one state agency and those individuals whom DMH has yet to find and/or identify as in need of mental health services. The statewide adult needs assessment enabled the Department to document the services needed and/or received by persons considered DMH priority consumers by virtue of their level of functioning. The numbers of individuals in the DMH planning population, however, does not translate directly into target numbers for one particular service or another (e.g., case management, residential beds, outpatient services, etc.). These are determined on an Area by Area basis along with an assessment of individual consumer need, DMH and/or other public or private resources available and generic or non-mental health resources available. Where specific numbers of consumers served are not available, DMH has presented capacity numbers. Throughout its **1995 State Plan**, DMH has attempted to set realistic yet meaningful goals and target numbers.

SECURING THE FUTURE

The two over-arching principles driving the Public Managed Care initiative are consumer empowerment and protecting the local service systems. The Department is committed to a consumer centered system that is driven by identified and expressed consumer need where consumers are full and active participants. Parents of minors as well as adolescents themselves also are actively involved. DMH is committed to establishing an organizational structure that can withstand political shifts and administrative changes within the Department that have previously undermined local autonomy.

Consumers and parents of minor children are integrally involved in CCSS planning and DMH policy development. They participated actively and in record numbers in locally based planning activities. These included training for and participation in consumer focus groups organized to test the validity of the needs assessment process and to formulate plans for the implementation of the initiative to establish a single residential code.

The Office of Consumer and Ex-Patient Relations (OCER), including both paid staff and volunteers, produces a quarterly newsletter, supervises a variety of consumer-run business ventures and planning projects, supports a consumer advisory council and participates on all of the Department's formal and informal policy, planning and topic-oriented work groups. The newest OCER staff member works exclusively with adolescents to increase their participation and access. These constituencies, as well as other advocates are represented on the state's Mental Health Planning Council.

Each of the seven DMH Area Offices has been reorganized as a public managed care entity allowing maximum local control over an array of individual comprehensive community support systems, including both contracted and state-operated services. Other infrastructure enhancements in place include a quality management system, uniform standards, criteria and protocols governing clinical programs and a developing utilization management system. Furthermore, the Department is in the process of establishing and training new citizen advisory boards in each Area and CCSS, pursuant to the issuance of new regulations in December 1993. The SFY'95 budget request to the legislature to reinstate Area based appropriations, an approach that recognizes the unique needs of each Area by permitting more flexibility in transferring funds between hospital and community accounts, was not approved.

The Department also intends to use updated prevalence data, as new methodologies for calculation become available, to ensure an equitable distribution of DMH resources. DMH continues to work with other state agencies, where appropriate, to ensure that the needs of adults and children with serious mental illness or severe emotional disturbance (as defined last year by the Center for Mental Health Services), are met. Continuous planning at the CCSS level will ensure that innovative community programming is expanded to meet the needs of DMH consumers.

THE 1995 BLOCK GRANT APPLICATION

The **1994 Implementation Report** and **1995 State Plan** are designed to highlight progress made by the Department during the last year and establish realistic and workable goals and objectives for State Fiscal Year 1995. As such, and in view of the Department's emphasis on creating an infrastructure for quality management, a utilization management system, standards of care for all service components and multi-year plans for each natural service area - all of which stress the need for integration and coordination to achieve the goal of a comprehensive system of community based care - both the **Implementation Report** and **State Plan** are structured to provide integrated data, wherever possible, for the adult and child/adolescent systems. Where goals and objectives are singularly addressed or applicable only to one or the other of those systems, however, they are clearly identified as such. The Plan and Implementation Report are both based on the state's fiscal year.

It should be noted that DHM submitted a spending plan (Requirement XII in the 1995 Plan) based on an estimated allocation of block grant dollars to the state for federal fiscal year 1995. The final allocation, notification of which was received by DMH after the submission date, was slightly lower than the estimate and will necessitate a revised spending plan.

1994 IMPLEMENTATION REPORT

REQUIREMENT #I: The State plan shall provide for the establishment and implementation of an organized community-based system of care for adults with a serious mental illness and children with a serious *emotional* disturbance.

In order to implement its Public Managed Care system, the Department has needed to institute quality and utilization management systems, develop uniform service standards, review and revise its policies, procedures and regulations, establish strong community structures and ensure the continued participation of consumers and families. Significant progress was made during SFY'94 in these areas.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Regulations and Standards

GOAL I/1: ESTABLISH AN ORGANIZATION-WIDE QUALITY MANAGEMENT PROGRAM.

Objective I/1a-S: Complete the quality management infrastructure by expanding quality assessment and improvement activities to the CCSS and service delivery level.

Indicator I/1a-S: Each CCSS submits a plan that is in compliance with the quality management standards identified as Principle Number 5, "quality services are assured through the maintenance of a comprehensive quality management program," in the CCSS Guidance Manual. **Accomplished**.

Comparison: Prior to SFY'94, the consistency and comprehensiveness of quality management activities varied from one Area Office to another. By the end of SFY'94, each Area Office defined, via its CCSS Plan, quality management roles and responsibilities consistent with the CCSS standards, and defined comprehensive processes for systematically monitoring and evaluating service delivery.

Objective I/1b-S: Begin the implementation of provider self assessment in all Area Offices to ensure ongoing and systematic monitoring and evaluation of provider performance.

Indicator I/1b-S: A work group chaired by the DMH Director of Monitoring and Evaluation and comprised of Area Office quality management staff develops guidelines for provider self-assessment activities. **Accomplished**.

Comparison: In SFY'93, DMH concentrated its efforts on developing a structure that would support integrated assessment and improvement activities across all DMH operated or funded programs. At the end of SFY'94, Area Office staff were implementing self-assessment activities, consistent with the self assessment guidelines, within their respective Areas.

GOAL I/2: IDENTIFY STANDARDS OF CARE FOR THE COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS.

SHARED OBJECTIVES

Objective I/2a-S: Develop a DMH Policy on standards of care.

Indicator I/2a-S: A Standards of Care Policy is drafted, approved by the Commissioner and Executive Staff and issued by DMH. **Accomplished**.

Comparison: The development of the Standards of Care Policy in SFY'94 created a core set of standards that apply to all programs and services either operated by or under contract to the Department. Prior to SFY'94, standards in areas such as quality management and utilization management were developed on a program by program basis and there were inconsistencies across programs depending on the year in which a particular set of program standards were developed.

Narrative: The objective was fully accomplished when a draft standards of care policy was submitted to the Policy and Planning Committee for review in December, 1993 and the Commissioner issued the DMH Standards of Care Policy on January 24, 1994.

Objective I/2b-S: Complete remaining program standards of care.

Indicators I/2b-S:

- A work group is convened to develop programmatic standards of care for the remaining adult day/evening program components (i.e. social clubs, partial hospitalization, day activities, day treatment, and vocational services) and submits its recommendations to DMH for review, comment and approval. **Accomplished.**
- In preparation for recontracting of DMH's residential system in SFY'95, a work group is convened to review and update the standards for residential programs previously developed in SFY'92. **Accomplished.**

Comparison: Prior to SFY'94, standards of care for the day/evening program component had been approved for community support clubhouses only. There were no standards for the other programs in the day/evening service component. In SFY'94, standards of care for the remaining day/evening program components were developed and submitted to the Commissioner for approval.

Residential standards were last developed in early 1992. The standards were updated to reflect changes in DMH's residential service system that occurred during the two years since the standards were first written.

Narrative: Program standards were drafted for all indicated programs, reviewed by the Department's Policy and Planning Committee and submitted to the Commissioner for approval. Therefore, the objective was accomplished. Given the number of programs affected by the residential standards, the Commissioner recommended that a focus group of consumers, family members, providers and DMH staff be established to review the residential standards prior to their adoption by DMH.

Objective I/2c-S: Maintain/expand certification and/or accreditation of state hospitals, inpatient units of state operated CMHCs and Intensive Residential Treatment Programs (IRTPs and CIRTs).

Indicators I/2c-S:

- All state hospitals and inpatients units of state operated CMHCs that were certified (nine facilities) at the end of SFY'93 maintain certification in SFY'94. **Accomplished**.
- All inpatient programs scheduled for an accreditation survey by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in SFY'94 are awarded accreditation. **Accomplished**.
- The four IRTPs maintain JCAHO accreditation and the two new Clinical Intensive Residential Treatment Programs (programs for young children, to replace services formerly provided at the DMH-operated Gaebler Children's Center) submit applications to JCAHO for accreditation. **Partially accomplished.**

Comparison: In SFY'93, nine of 12 state operated inpatient facilities were certified and four were accredited. In SFY'94, all inpatient facilities previously accredited and/or certified maintained accreditation/certification and two additional state operated inpatient facilities successfully achieved JCAHO accreditation. However, one of the IRTPs, lost its accreditation during the year.

Narrative: When one of the IRTPs lost its accreditation, the Department moved quickly to help the program locate more suitable space and to correct the deficiencies that led to loss of accreditation. These activities were pursued

vigorously and the Department expects that the program will be able to submit its application for re-accreditation in SFY'95.

Objective I/2d-S: Complete revision of residential program definition.

Indicator I/2d-S: A work group is convened to assess the Department's residential program codes and to develop a definition of residential services that would allow DMH to more flexibly respond to consumer preference and level of care need. **Accomplished.**

Comparison: In SFY'93, DMH employed over 12 program codes to define its residential service system. Each program code represented a specific type of residential program (i.e. high intensity residence, moderate intensity residence. low intensity residence, etc.)

Based on a description of residential services that identifies the generic components of any residential program, the number of program codes was reduced from 12 to two in SFY'94. The change will allow residential providers greater flexibility in responding to consumer need and preference.

Narrative: The objective was fully accomplished when the Single Residential Program Code for Adult Programs and the Single Residential Program Code for Child/Adolescent Programs were approved by the Commissioner in May 1994 for use in SFY'95 Requests for Proposals (RFPs.)

GOAL I/3: ENSURE THAT THE STATUTES, REGULATIONS AND POLICIES THAT GOVERN THE DEPARTMENT OF MENTAL HEALTH ARE COMPATIBLE WITH PUBLIC MANAGED CARE AND THE MAINTENANCE AND EXPANSION OF COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS, WHILE CONTINUING TO PROTECT THE LEGAL AND HUMAN RIGHTS OF CONSUMERS.

SHARED OBJECTIVES

Objective I/3a-S: Issue new regulations governing the establishment of citizen advisory boards.

Indicator I/3a-S: Regulations governing the establishment of citizen advisory boards are issued. **Accomplished.**

Comparison: In SFY'93, regulations governing the citizen advisory boards did not accurately reflect the organization of the Department, particularly its establishment of Comprehensive Community Support Systems (CCSSs) in each of the state's natural service areas. This was corrected with the issuance of new regulations for Area Boards and CCSS Advisory Boards, as well as updated

regulations for the Statewide Advisory Council, Hospital Boards of Trustees and the Statewide Human Rights Advisory Committee.

Narrative: The old regulations did not require all advisory boards to include elders, parents of children, adolescents and representatives of all significant ethnic or minority groups in the Area/CCSS as members, although they did encourage the appointment of consumers and family members to the boards. After the regulations were issued, in December 1993, each Area Director began an intensive process to recruit and train members for the newly established boards. The first group of nominees was appointed by the Commissioner and sworn in by local magistrates, although the recruitment and appointment process is ongoing. Also, the Department began to develop a handbook for advisory board members, which will be used for statewide orientation and training.

Objective I/3b-S: Establish a task force of DMH staff and other interested parties to develop recommendations for changes in the citizen advisory board structure. Recommend any required changes to statute or regulations and a plan for educating legislators regarding the needed changes.

Indicator I/3b-S: A task force is established and meets monthly to develop recommendations for changes to the Department's enabling statute, including those sections affecting the citizen advisory board structure. **Accomplished**.

Comparison: No such task force existed in SFY'93.

Narrative: A task force, comprised of DMH staff, consumers, family members and advocates for children, the elderly and human rights, met monthly to examine various sections of the enabling statute, Chapter 19. During that time, various sections were redrafted, including the opening "mission statement." However, the group expressed doubts about the wisdom of attempting to revise the statute when there was so much uncertainty regarding future changes to the health care system, both nationally and on the state level, and how those changes would ultimately affect DMH. At the end of SFY'94, it was unclear how and whether the task force would continue.

Objective I/3c-S: Continue systematic review of all DMH policies and regulations as needed and establish a schedule for annual review of all internal DMH policies.

Indicator I/3c-S: A Policy Review and Development subcommittee of the Department's Policy and Planning Committee meets bi-weekly to systematically review all of the Department's internal policies as well as standards of care, practice guidelines and other directives. As the subcommittee completes its review, recommendations for maintaining, revising or discarding policies or

issuing new ones are sent to the Policy and Planning Committee for consideration before going to the Commissioner and Executive Staff for final approval. **Accomplished**.

Comparison: The subcommittee began operating in SFY'93 and maintained its schedule in SFY'94.

Narrative: The subcommittee structure was established and one revised policy issued in SFY'93 (seclusion and restraint). Three new and two revised policies (new policy guidelines, standards of care, HIV/AIDS, special state employees, mandatory forensic reviews) were issued in SFY'94. The two committees also sent policies (smoking, criminal record information) to Executive Staff for approval in SFY'94 that had not been acted on by the end of the fiscal year. In addition, the committees reviewed and approved standards, clinical criteria and practice guidelines for the continuum of care within the Comprehensive Community Support Systems. These documents will be compiled in a Standards Manual for the Department.

Planning

GOAL I/4: ESTABLISH AN ADMINISTRATIVE STRUCTURE WHICH SUPPORTS DEVELOPMENT AND MANAGEMENT OF LOCALLY BASED COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS AS THE BASIS OF DMH PUBLIC MANAGED CARE.

SHARED OBJECTIVES

Objective I/4a-S: Complete restructuring of Area offices; redeploy resources as necessary, in conjunction with CCSS needs assessment and staffing analysis, to ensure that funded services are in line with consumer need and preference and that all Area offices and CCSS sites are appropriately staffed (e.g., Quality Management, Case Management, Medical Director, Fiscal and Core Services, Community Programs, Program Evaluation, Human Rights, etc.).

Indicator I/4a-S: Each Area office conducts a self-assessment of organizational restructuring, to be reviewed and evaluated for compliance with established standards for appropriate staffing patterns. **Accomplished**.

Comparison: In SFY'93, Area offices submitted reorganization plans, including a plan for redeployment of human and fiscal resources, to assure that Area and CCSS site staff would be able to address critical functions. In SFY'94, each Area office conducted a self-assessment of its organizational restructuring,

to be evaluated for progress toward meeting established restructuring standards. Significant restructuring progress was achieved in six of seven Areas. Annual Area Performance Indicators also were developed by the Department to measure the effectiveness of the CCSS and Area organizations' delivery of services.

Narrative: Area office restructuring standards govern the development and management of Area and CCSS organizational structures, and Annual Area Performance Indicators measure systems performance for hospital usage, community placement tenure, service accessibility and accreditation and certification as well as revenue production and the management of resources.

Objective I/4b-S: Complete initial planning process in each CCSS; integrate multi-year CCSS plans into new statewide multi-year plan.

Indicator I/4b-S: CCSS plans are completed by June 30, 1994 and used to establish the priorities and budget of the agency. Multi-year plans are presented to the Commissioner. **Accomplished.**

Comparison: In SFY'93, six of seven Areas submitted CCSS plans for adults, adolescents and children. In SFY'94, the first three-year CCSS plans were submitted (on 9/30/93) and evaluated. Corrective action plans were then submitted on 6/30/94. Requests for new funds were rated to determine which would be supported by DMH in the SFY'96 budget. Final determinations were made by the Commissioner and the State Advisory Council based on issues of fiscal equity, compliance with CCSS plans, need and Commissioner's priority. A report on CCSS planning data was compiled and disseminated.

Narrative: Each CCSS plan was rated on 36 planning standards by a team of cross-divisional staff and State Advisory Council members, and a detailed narrative analysis of each plan completed. Over 90% of the plans were rated at least at Significant Compliance. CCSS planning standards will be refined as necessary over time to improve systems functioning.

Objective I/4c-S: Develop ongoing strategies with other mental health advocates to focus on inclusion of coverage for mental health services in national health care reform; continue to educate state and national legislators regarding Massachusetts' mental health system and the potential impact of proposed reforms on the state.

Indicator I/4c-S: Meet bi-monthly or more often, as needed, with a group of mental health advocates to review current proposals before the Congress regarding health care reform. Continue to advocate for parity between mental

health and general health care in any legislation that emerges. Communicate regularly, by letter or in person, with members of the congressional delegation. **Accomplished**.

Comparison: Meetings with advocates that began informally in SFY'93 were formalized in SFY'94 as Congress began to seriously consider health care reform.

Narrative: The group, which emerged as an ad hoc subcommittee of the Commissioner's Advocates Breakfast, included advocates for children, the elderly, consumers, cultural minorities, community programs and the public sector (DMH). In addition to regular meetings, an emergency telephone/fax tree was established so that communications could be sent to members of Congress on short notice, if necessary.

Consumer and Community Involvement

GOAL I/5: ENSURE THE CONTINUED PARTICIPATION OF CONSUMERS AND FAMILY MEMBERS, INCLUDING PARENTS OF CHILDREN AND ADOLESCENTS, AND MEMBERS OF RACIAL AND LINGUISTIC MINORITY GROUPS AT THE CCSS, AREA AND CENTRAL OFFICE LEVELS OF DMH.

SHARED OBJECTIVES

Objective I/5a-S: Develop consumer satisfaction measures for all service types.

Indicator I/5a-S: Consumer satisfaction questionnaires are completed for all service types, including long-term inpatient services. **Accomplished**.

Comparison: At the end of SFY'93, the following consumer satisfaction questionnaires were completed: supported employment; work activities; psychiatric day treatment; residential services; community support clubhouse; acute inpatient services.

Narrative: In addition to completing the series of consumer questionnaires referenced above, DMH also began developing a consumer questionnaire in SFY'94 to measure overall satisfaction with psychiatric residency services, i.e. satisfaction with the quality of care received by consumers in DMH facilities, from psychiatric residents.

Objective I/5b-S: **Continue the work of the Multi-Cultural Advisory Committee (MCAC) to expand access to mental health**

services for people of color and cultural and linguistic minorities.

Indicator I/5b-S: In response to a survey, a resource directory, including the names of approximately 300 persons of color (consumers, family members, clinicians, et al.) in the area of mental health, is prepared for printing. This document includes references for child and adult services and enhances access to those services for all minorities. **Accomplished**.

Comparison: The number of survey responses has progressively increased since SFY'93. Requests for resources also increased.

Narrative: Access continues to improve with the distribution and sharing of information. Dissemination of information in the resource directory has begun prior to printing.

Objective I/5c-S: **Incorporate Grand Rounds throughout the state to focus on cultural and linguistic treatment issues, as a first step in ongoing education regarding services for people of color.**

Indicator I/5c-S: Two Grand Rounds are presented, focused on people of color and/or ethnic populations. **Accomplished**.

Comparison: No Grand Rounds focused on people of color were held in SFY'93.

Narrative: Two Grand Rounds were presented in March 1994 on the Hispanic/Latino population (adults and children). The Rounds were held at Worcester State Hospital and at Health and Education Services, Inc., a DMH provider in Peabody, MA. Also in SFY'94, planning occurred for a series of Grand Rounds to be held in SFY'95 to encompass all ethnic groups of color, including South East Asians, Latinos, Hispanics, African/Americans, Haitians, Native Americans and others.

Objective I/5d-S: Continue to explore mechanisms to fully actualize a Multi-Cultural Mental Health Research and Education Center.

Indicator I/5d-S: A Center Director and Grants Coordinator are appointed for the Multi-Cultural Mental Health Research and Education Center. A commitment of seed money from the University of Massachusetts Medical Center is received and a dialogue with Harvard and Boston Universities is begun, to garner additional support. Approximately eighty (80) researchers have made commitments to the Center. Involvement includes child and adult issues.

Planning for eventual submission of a funding proposal to NIMH for grant support continues. **Accomplished**.

Comparison: In SFY'93, the focus was on planning only. A conference was held in February 1994 at the Kennedy Library entitled "Systematic Integration of Multicultural Issues" at which appointments and academic commitments to the Center were made.

Narrative: The planning committee is working hard to identify funding sources to support the actual writing of a grant proposal to NIMH. Finding financial support continues to be a challenge and a barrier to fully actualizing the formal establishment of the Center.

Objective I/5e-S: Select and devise an action plan for implementation of at least one recommendation from the MCAC's SFY'93 report in each focus area (i.e., family support, DMH services, rehabilitation, human resources, provider role, grants and foundations).

Indicator I/5e-S: An action plan is developed, including the following:

- Integrate the MCAC into the Statewide Advisory Council to ensure institutionalization of the committee;
- Extend the interpreter services of the DMH Refugee Assistance Program;
- Continue planning for the establishment of a Multi-cultural Research and Education Center;
- Provide education for families and DMH staff through Grand Rounds and MCAC meetings;
- Assist Area Directors and CCSS staff with inclusion of multicultural issues in Area and CCSS plans;
- Provide references, as requested, to DMH and its affiliates for experienced mental health workers of color.

The objective was accomplished.

Comparison: The committee's recommendations were expanded and made more specific in SFY'94. However, this is an on-going process.

Narrative: Implementation has proceeded, but has been restrained by the limited availability of resources to support the chairperson (a DMH staff person), committee members and the committee's various activities. The primary contribution of resources to support the committee's work has been the Department's support of the chairperson's salary. Also, the DMH Refugee Assistance Program was able to focus additional resources on the needs of specialized populations in the western part of the state in SFY'94. Additional resources will be needed to completely implement the committee's agenda.

CHILD ONLY OBJECTIVE

Objective I/5f-C: Create a staff position in the Office of Consumer and Ex-Patient Relations (OCER) to address the concerns of children and adolescents.

Indicator I/5f-C: A Child/adolescent organizer is hired and begins working to address the concerns of children and adolescents. **Accomplished**.

Comparison: During SFY'93, the parent representatives on the Consumer Advisory Council advocated for such a position within OCER. The position was approved, job description developed and an individual hired in SFY'94.

Narrative: The membership of the Consumer Advisory Council includes adult and adolescent consumers and parents of children and/or adolescents. It advises OCER and the Commissioner on issues of concern to consumers.

REQUIREMENT #II: The State plan shall contain quantitative targets to be achieved in the implementation of an organized community-based system of care, including the numbers of individuals with serious mental illness or serious emotional disturbance residing in the areas to be served under such system.

To increase the effectiveness of its planning, the Department has continued efforts to improve its management information systems, and to achieve service integration for populations with special needs such as people who are deaf and hard of hearing, those who have substance abuse problems, the elderly and those in need of forensic services.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Targeted Population to be Served

GOAL II/1: IDENTIFY AND PLAN SERVICES FOR ELIGIBLE CONSUMER POPULATIONS.

SHARED OBJECTIVES

Objective II/1a-S: Determine the number of consumers to be served in each DMH Area based on each Area's approved first

year (SFY'94) Comprehensive Community Support System (CCSS) plan.

Indicator II/1a-S: Each CCSS submits a plan; each plan stipulates the number of consumers to be served, including numbers of consumers with special needs such as the elderly, children, dually diagnosed, etc., in which programs, for an estimated cost. **Partially accomplished** (see Narrative).

Comparison: In SFY'94, after two years of planning, six of seven Area's CCSS plans were submitted to the Commissioner. The Metro Boston Area is on a later timetable (July 1994). No CCSS plans had previously been submitted.

Narrative: Planning population estimates are established using accepted statistical modeling techniques for determining incidence and prevalence of mental illness. Federal incidence and prevalence indicators are incorporated into ongoing planning efforts. After the CCSS plans were submitted and reviewed, gaps were identified and Areas were required to file corrective action plans. These were submitted by June 30, 1994. All Areas are due to submit their updated CCSS plans by 6/30/95 according to revised standards.

The identification of service needs in each CCSS (natural service area) is new information and was gathered with the assistance of consumers and advocates. With the exception of the Metro Boston CCSS plans, this objective was accomplished.

Objective II/1b-S: Maintain the staffing levels required to provide at least the amount of service provided to consumers in SFY'93, including special and sub-populations.

From its Client Registry, DMH is able to produce an unduplicated count of individuals served through case management, inpatient and residential (certified "rehab option") services only. The **Indicators** are the number of consumers served in SFY'94.

- Adult consumers served

	Case Management		Inpatient		Resid/Rehab Option	
DMH Area	SFY'93	SFY'94	SFY'93	SFY'94	SFY'93	SFY'94
Metro Boston	1,053	1,083	1,507	1,342	659	728
North East	1,652	1,832	489	529	680	691
Southeastern	2,212	2,457	447	587	796	811
Metro West	933	994	17	155	459	489
Metro South	886	944	216	220	315	339
Central Mass	1,170	1,209	10	416	584	637
Western Mass	1,287	1,317	337	378	631	617
Total	9,193	9,836	3,023	3,627	4,124	4,312

Narrative: **Inpatient** refers to acute and continuing care patients in state-operated community mental health centers (CMHCs) and DMH-contracted replacement units in general and private psychiatric hospitals only; the Metro Boston and Western Mass. Areas have no state hospitals; the Western and Central Mass. and Metro West Areas do not have state-operated CMHCs; replacement units in Central Mass. and Metro West opened just before the close of SFY'93, thus the low number of admissions (state hospital admissions are not included); "residential" counts only those consumers Medicaid-eligible for "rehab option" services and does not include approximately 700 consumers receiving other residential services (e.g., supported housing).

- Child/adolescent consumers (under 19) served

	Case Management		Inpatient		Resid/Rehab Option	
DMH Area	SFY'93	SFY'94	SFY'93	SFY'94	SFY'93	SFY'94
Metro Boston	295	317	56	33	41	44
North East	307	288	51	37	79	70
Southeastern	329	388	47	36	57	40
Metro West	105	81	19	15	28	22
Metro South	88	96	15	10	15	13
Central Mass	165	168	27	15	47	48
Western Mass	184	178	24	25	94	87
Total	1,473	1,516	239	171	361	324

Narrative: There are no DMH-operated inpatient units for children. Children under 19 included in the above chart represent continuing care admissions to one contracted replacement unit for latency age children and three contracted adolescent units. DMH does not contract for acute care beds for children or adolescents; they receive acute care in general and private psychiatric hospitals, funded through insurance, Medicaid or free care. SFY'94 residential totals do not include approximately 50 non "rehab option" eligible children.

Deaf and Hard of Hearing

- Deaf and hard of hearing consumers served

	Case Mngmnt		Inpatient	Residential/Rehab Option
SFY'94 only	adult s	c/a	adults and c/a	adults and c/a
deaf	45	1	80 admissions	35 (received 43 placements)
profoundly hard of hearing	66	2	102 admissions	60 (received 88 placements)
Total	111	3	182	95

Narrative: Comparable numbers for SFY'93 are unavailable. However, the estimate of deaf or hard of hearing consumers who received DMH services in SFY'93 as determined by a needs assessment conducted by the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH) for the DMH CCSS planning process was 47. In its 1994 State Plan, DMH committed to serving at least 47 deaf or hard of hearing consumers, based on the needs assessment.

Mental Illness and Substance Use

- Adults with mental illness/co-occurring psychoactive substance use disorder (PSUD) served

	Case Mnged/PSUD		Inpatient/PSUD		Resid/PSUD	
DMH Area	SFY'93	SFY'94	SFY'93	SFY'94	SFY'93	SFY'94
Metro Boston	368	379	829	738	231	255
North East	578	641	269	291	238	242
Southeastern	774	860	246	323	279	284
Metro West	326	348	9	85	161	171
Metro South	310	330	119	121	110	119
Central Mass	409	423	5	229	204	223
Western Mass	450	461	185	208	221	216
Total	3,215	3,442	1,662	1,995	1,444	1,510

Narrative: Department surveys indicate that 35% of the adult population (including elders) have active or intermittently active substance abuse problems as do 55% of those admitted for inpatient care. Therefore, after applying these percentages to DMH priority consumers in the DMH Client Registry, the Department estimates it served 3,442 case managed individuals with co-occurring substance use disorders, 1,995 inpatients and 1,510 through (certified "rehab option") residential services in SFY'94. Although within each category the count is unduplicated, the same consumer may be counted within more than one category. "Inpatient" includes acute and continuing care patients in state-operated community mental health centers and DMH-contracted replacement units in general and private psychiatric hospitals only.

- Children/adolescents with mental illness who also abuse substances served

	Case Managed	Inpatient	Residential/Rehab Option	
DMH Area			SFY'93	SFY'94
Metro Boston	N/A	N/A	29	31
North East	N/A	N/A	55	49
Southeastern	N/A	N/A	40	28
Metro West	N/A	N/A	20	15
Metro South	N/A	N/A	11	9
Central Mass	N/A	N/A	33	34
Western Mass	N/A	N/A	66	61
Total	N/A	N/A	254	227

Narrative: Surveys of adolescents in residential programs have shown that 70% have had active or intermittently active substance use problems. Providers have been asked to carefully review the manner in which treatment for substance abuse is addressed in their programs and to provide appropriate interventions. DMH estimates that 227 adolescents with substance use problems living in residential programs were served in SFY'94.

Elders

- Elderly consumers served

	Case Management		Inpatient		Resid/Rehab Option	
DMH Area	SFY'93	SFY'94	SFY'93	SFY'94	SFY'93	SFY'94
Metro Boston	43	42	38	26	21	25
North East	66	62	7	10	14	16
Southeastern	157	160	15	18	39	38
Metro West	38	38	0	1	23	23
Metro South	26	30	1	2	6	4
Central Mass	84	76	0	2	19	16
Western Mass	130	130	14	5	93	93
Total	544	538	75	64	215	215

Narrative: Although within each category the count is unduplicated, the same consumer may be counted in more than one category. See "inpatient" definition under Objective II/1a Narrative. **Note:** DMH has two specialized elder inpatient units in its own hospitals in the Metro West and Central Mass. Areas. Admissions to these units are **not** included in the chart above.

Forensically Involved Consumers

Objective II/1c-S: Provide forensic evaluations and/or treatment for all individuals referred to DMH through the criminal justice system.

Indicators II/1c-S: The number of consumers served in SFY'94.

- Adults involved with the criminal justice system

	Inpatient Evaluations		Court Clinic Evaluations	
DMH Area	SFY'93	SFY'94	SFY'93	SFY'94
Metro Boston	161	250	2,734	2,449
North East	18	23	1,422	1,264
Southeastern	19	2	1,036	1,060
Metro West	1	9	354	234
Metro South	3	5	658	447
Central Mass	0	10	646	832
Western Mass	85	82	1,122	926
Total	287	381	7,992**	7,212

Note: Most forensic evaluations take place in state hospitals. Therefore, the inpatient data for adults (above), accounting for evaluations in CMHCs or replacement units only, represent just a fraction of forensic evaluations performed (27% of the total in SFY'93 and 36% in SFY'94 respectively). **It is likely that SFY'93 adult court clinic evaluation data include some juveniles who were evaluated in district court juvenile sessions. The SFY'94 data system corrected this reporting problem.

- Children and adolescents involved with the criminal justice system

	Inpatient Evaluations		Court Clinic Evaluations	
DMH Area	SFY'93	SFY'94	SFY'93	SFY'94
Metro Boston	N/A	N/A	648	1,242
North East	N/A	N/A	N/A	750
Southeastern	N/A	N/A	179	98
Metro West	N/A	N/A	N/A	102
Metro South	N/A	N/A	N/A	296
Central Mass	N/A	N/A	175	106
Western Mass	N/A	N/A	140	408
Total	N/A	36 (statewide)	1,142**	3,002**

Note: The adolescent inpatient evaluations were performed in the DMH-contracted adolescent units located at Taunton and Westborough State Hospitals. These units serve adolescents across the state. **SFY'93 data include juvenile court evaluations exclusively; SFY'94 data include evaluations in juvenile court as well as district courts sitting in juvenile session.

Narrative: The Department performs evaluations and provides treatment for all individuals referred through the criminal justice system, including determination of competency to stand trial, determination of criminal responsibility, need for hospitalization, aid in sentencing, observation and examination. Forensic services are provided to court clinics and county houses of correction and in DMH-operated facilities and DMH-contracted replacement units. The Department's forensic division maintains a data base of adults and children referred to court clinics and those admitted to inpatient facilities for evaluation and/or treatment. The data represent the number of evaluations performed in inpatient facilities or court clinics during SFY'93 and '94, not the number of individuals seen. Individuals may have received more than one evaluation during the year or may have been evaluated at a court clinic and subsequently admitted to an inpatient unit.

GOAL II/2: ACHIEVING SERVICES INTEGRATION FOR SPECIAL AND SUBPOPULATIONS REQUIRES BOTH STATEWIDE AND LOCAL PLANNING AND IMPLEMENTATION. THEREFORE, THE CURRENT YEAR'S GOAL COVERS BOTH STATEWIDE

AND LOCAL STRATEGIES. THIS INCLUDES MAINTAINING EXISTING STATEWIDE INITIATIVES AND IMPLEMENTING NEW ONES AS WELL AS IMPLEMENTING RECOMMENDATIONS IN THE FIRST YEAR (SFY'94) CCSS MULTI-YEAR PLANS RELATIVE TO THESE GROUPS.

SHARED OBJECTIVES

Deaf and Hard of Hearing

Objective II/2a-S: Address the case management needs of deaf and hard of hearing consumers in the statewide case management services plan.

Indicator II/2a-S: Analyze existing DMH data base for: 1) prevalence of deaf and hard of hearing consumers admitted for inpatient treatment; 2) current case management utilization patterns by deaf and hard of hearing consumers. **Accomplished**.

Comparison: In SFY'93, case management planning activities did not specifically address special needs populations such as the deaf and hard of hearing. (Special populations were to be considered in phase two, during SFY'94).

Narrative: The analysis provided information about deaf and hard of hearing consumers likely to need case management services. The survey was coordinated with an Interagency Task Force (Objective II/2b-S) which is studying and planning for the needs of the hearing impaired.

Objective II/2b-S: Develop a statewide planning document; identify barriers to gaining access to services and institute a plan to assure that deaf and hard of hearing children with SED needing inpatient services will be served in linguistically appropriate settings in which clinical staff has the ability to sign; and begin work on the design of a collaborative case management approach between DMH and MCDHH.

Indicator II/2b-S: A draft statewide plan for mental health services for consumers who are deaf or hard of hearing is developed; a statewide Steering Committee chaired by DMH and MCDHH Commissioners is established with an initial focus on inpatient planning (this initiative has a separate committee reporting to the Steering committee); Area CCSS plans and corrective actions include specific actions for serving this population. **Accomplished**.

Comparison: The emphasis on statewide and CCSS planning in SFY'94 resulted in increased awareness of the needs of this special population in each Area and CCSS over that which existed in SFY'93.

Narrative: The collaboration between DMH and MCDHH has been positive, involving consumers, providers and advocates, laying the foundation for the SFY'95 focus on the role of current DMH-operated inpatient services (DMH operates a 10-bed Deaf Unit at one of its state hospitals). The groundwork for this discussion and planning was set in SFY'94. The CCSS planning process is beginning to lay the foundation for more inclusion and response for deaf consumers with mental illness. More work is needed in the areas of staff training, interagency linkages and access to interpreters and specialized staff and programs. The Steering Committee is charged with setting the direction and oversight for these changes.

Mental Illness and Substance Abuse

Objective II/2c-S: Establish DMH/DPH local dual diagnosis task force in each Area to develop services integration strategies on the local level.

Indicators II/2c-S:

- DMH encourages development of local work groups through requirements in the CCSS planning process. **Accomplished**.
- DMH appoints an addiction specialist to provide leadership to the Department in developing services integration strategies and for liaison with the Department of Public Health, Bureau of Substance Abuse. **Accomplished**.

Comparison: In SFY'93, coordination and support activities were carried out by a staff person not specifically trained in both addiction and mental health.

Narrative: The Department of Public Health and DMH have collaborated effectively in the development of interagency work groups in four of the seven regions/areas of the state, with plans to complete development in SFY'95. In many instances, these local work groups have provided technical assistance to the local mental health planning process.

Objective II/2d-S: Continue Statewide Task Force on Dual Diagnosis to provide technical assistance to local groups.

Indicator II/2d-S: The State Wide Task Force develops a strategy for supporting development of local groups. Accomplished.

Comparison: In SFY'93, informal support was available from existing local work groups and from the Statewide Task Force. In SFY'94, this was formalized

through the following mechanisms: 1) local groups send representatives to the Statewide Task Force meetings and carry back information to their local groups; 2) the Statewide Task Force coordinates requests for consultation or support to local groups.

Narrative: Local work groups have expressed a high degree of satisfaction with this arrangement and are active participants on the Statewide Task Force. Part of the strength of this model is the collaboration between DMH and DPH supporting the development.

Objective II/2e-S: Convene an expert panel to develop recommendations to the Commissioners of Mental Health and Public Health for a statewide dual diagnosis plan.

Indicator II/2e-S: Convene an expert panel to develop a statewide plan on dual diagnosis. **Not accomplished**. (See Narrative below)

Comparison: Historically, services planning was an independent activity of each department.

Narrative: The strategy of convening an expert panel is one that has been used in other states to articulate a blue print for services integration for persons who are both addicted and mentally ill. However, the Commissioners of Mental Health and Public Health preferred a more flexible strategy, specifically the establishment of an ongoing working group to develop recommendations for specific services integration projects and strategies (please see Objective II/2f-S). Therefore, a substitute strategy was pursued.

Objective II/2f-S: Continue to review, with DPH, priorities for collaboratively funded projects, based on the joint survey and needs assessment results (2 year project).

Indicator II/2f-S: An interagency work group is established. **Accomplished**.

Comparison: Interagency planning previously consisted of periodic meetings between the Commissioners and staffs of the two agencies. The working group, composed of senior staff from DMH and DPH as well as representatives from the Division of Medical Assistance (DMA) and representatives from the Statewide Task Force on Dual Diagnosis, met monthly to develop recommendations to the Commissioners on service system development and integration.

Narrative: An interagency steering committee was established (SFY'94) with quarterly reports to and meetings with the Commissioners to establish priorities.

The goal for SFY'95 is to begin fielding model services integration projects involving the two agencies.

Objective II/2g-S: **Continue discussions with DPH regarding a second jointly sponsored dual diagnosis conference, in calendar year 1994.**

Indicator II/2g-S: Interagency conference planning committee is established and funded. **Accomplished**.

Comparison: Previous conferences appealed primarily to mental health providers only. This conference is targeted to providers from DMH and DPH.

Narrative: The all day conference will be held in SFY'95.

ADULT ONLY OBJECTIVES

Objective II/2h-A: **Fund manualization of a skills-based relapse prevention technology developed originally under federal grant #RO1-MH46335 ("Treating Substance Abuse Among Chronic Mental Patients") for severely impaired dually-diagnosed adults.**

Indicator II/2h-A: Funding is secured. **Accomplished**.

Comparison: No funds were available previously to carry on the work described above.

Narrative: This technology will be integrated into ongoing programs sponsored by or funded by DMH. The staff and patient instruction manuals were completed in SFY'94, with trials in the case management program, a residential program, and a supported work program to be conducted during SFY'95-96.

Objective II/2i-A: **Develop a statewide training strategy in dual diagnosis for all state-sponsored, state-funded, or state-run programs (to be implemented in SFY'96).**

Indicator II/2i-A: A Training Committee is established to review objectives. **Accomplished**.

Comparison: IN SFY'93, training was delivered through one-day workshops but no overall strategy was in place.

Narrative: As part of the interagency collaboration described under Objective II/2-f, curriculum is being developed and modeled at the program level in one of the pilot areas of the state. These efforts included interagency staff exchanges, lectures, case presentations, etc. These activities will serve as a laboratory for clarifying the types of training activities that are meaningful to skills development in the field.

Objective II/2j-A: **Continue the work of the Elder Mental Health Subcommittee of the Mental Health Planning Council, including completion of its report to identify service gaps and make specific recommendations with regard to the improvement of services. Integrate the results of this report with data obtained through the CCSS Planning Process.**

Indicator II/2j-A: A report from the subcommittee, identifying service gaps and containing recommendations for improving services to elderly consumers, is submitted to the Commissioner. **Accomplished**.

Comparison: The subcommittee had just formed in SFY'93 and had not yet formulated any recommendations to be submitted to the Department.

Narrative: The initial recommendations of the Elder Mental Health Subcommittee were completed and provided to the Commissioner in December 1993. They were reviewed by the Policy and Planning Committee, slightly modified, and subsequently approved by Executive Staff prior to the end of SFY'94. The Commissioner recommended they be sent back to Policy and Planning for implementation, i.e. integration of the recommendations into DMH policies and procedures. The intention was to ensure that implementation was accomplished in accordance with CCSS planning, in the Areas. This task will be completed in SFY'95, including a follow-up inquiry after January 1, 1995 to ensure compliance throughout the state with the recommendations. These recommendations will have a significant effect on how elders are treated within the DMH system and particularly on how the Designated Emergency Programs operate.

Objective II/2k-A: **Use Block Grant funds to establish a gerontological training program to provide specialized training for mental health professionals who serve older persons with mental illness. The program will include theory and field experience and will lead to certification in gero-psych issues.**

Indicator II/2k-A: A gerontological training program is established. **Accomplished**.

Comparison: There was no training program in SFY'93. Two of the four planned training conferences were held in SFY'94 and two are planned for SFY'95.

Narrative: Two of the four regional conferences on the unique needs of the elderly mentally ill were planned for calendar year, 1994. Attendance at the two held in SFY'94 was superb and more than 300 DMH and vendor professionals received Continuing Education Credit for their attendance. Renowned professionals in the field made presentations and held workshops at both conferences. Feedback from the first conference indicated a preference for fewer workshops and more time to discuss pertinent issues. Those changes were made in the second conference. Both conferences received overwhelmingly positive evaluations from attendees and presenters. Certification as a goal was abandoned as the probability of 2 days attendance (to include field experience) was slight.

Forensically Involved Consumers

ADULT ONLY OBJECTIVES

Objective II/2I-A: Refine and expand the forensic inventory and data base

Indicator II/2I-A: Through a contractual arrangement with the University of Massachusetts Medical School's Law and Psychiatry Program, the Department data collection capacity is refined, enabling it to generate monthly reports regarding forensic services offered in the courts as well as accurate and timely information about all patients committed under forensic evaluation and/or continuing care sections of MGL c.123. **Accomplished.**

Comparison: At the end of SFY'93, the forensic division was unable to identify by court the numbers and types of evaluations requested, or whether they pertained to adult or juvenile defendants.

Narrative: Efforts during SFY'94 in the area of data collection allowed DMH to develop a system of ongoing monitoring of the clinical status of forensic patients. Also developed were data forms that will provide accurate and timely information about the types and volume of court ordered forensic evaluations, as well as the routines and rhythms of the various courts to whom DMH provides services. Additionally, significant progress was made in identifying the forensic patients in DMH's inpatient system and in identifying the forensic population at Bridgewater State Hospital (a Department of Correction facility) whose patients will eventually be returning to the DMH service system.

Objective II/2m-A: Continue to refine and expand DMH inpatient secure capacity.

Indicator II/2m-A: Coordination among the forensic division, DMH Areas and inpatient facilities is increased, thereby increasing the capacity for shared decision making concerning forensic patient supervision status at critical points during the inpatient stay. Inpatient data collection and clinical consultations increase public safety by allowing expert review of high risk patients before their release from locked settings and prior to discharge. **Accomplished**.

Comparison: Historically, most forensic patients in need of evaluation or continuing care were treated generically within the DMH inpatient system regardless of their security needs.

Narrative: The ability to consolidate and focus more specifically on the treatment needs of the forensic inpatient population has allowed DMH to adopt a system of forensic care that is sensitive to the special legal requirements of the criminal justice system as it relates to the forensic inpatient.

During SFY'94, in an effort to enhance clinical capacity for the treatment of forensic patients, the Department consolidated acute forensic evaluation services and established more specialized inpatient services for forensic patients requiring continuing care.

Objective II/2n-A: Expand and refine forensic continuing care capacity.

Indicator II/2n-A: Training is provided to inpatient clinicians providing care and treatment to patients requiring forensic evaluation and continuing care, increasing both their general understanding of the special needs of this population and their level of comfort with patients whose history may include violence and criminal behavior. **Accomplished**.

Comparison: Prior to SFY'94, forensic patients had few specialized or organized continuing care options in the DMH inpatient system.

Narrative: In SFY'94, a secure evaluation unit and a continuing care service were opened at Worcester State Hospital to serve the Central and Western Massachusetts Areas. Provisions were made to do acute forensic evaluations at the Erich Lindemann Mental Health Center for the Metro Boston Area, and acute forensic evaluations in the Southeastern Massachusetts Area were consolidated in a newly developed unit at Taunton State Hospital. In addition, the Taunton Secure Care Unit, operated by Justice Resource Institute, a private vendor, continues to provide statewide evaluations and secure continuing care and treatment services for 12 women and 13 men.

CHILD ONLY OBJECTIVE:

Objective II/2o-C: Reassess, and refine as appropriate, DMH inpatient forensic capacity for children and adolescents.

Indicator II/2o-C: Develop admission and special UR mechanisms for use in juvenile inpatient settings that provide services to forensic patients. **Accomplished**.

Comparison: In SFY'93, there was no quality control mechanism for use in the juvenile inpatient settings, and no clear admission standards for juvenile forensic inpatient situations.

Narrative: During SFY'94, the DMH forensic division developed and implemented a centralized capacity for tracking juvenile and adolescent forensic patients, and a system for maintaining information regarding their inpatient status and discharges.

Management Information Systems

GOAL II/3: CONTINUE PLANNING FOR IMPLEMENTATION OF THE CONSUMER REGISTRATION AND ENROLLMENT SYSTEM IN A MANNER THAT ASSURES ACCURACY OF INFORMATION AND PROTECTS THE PRIVACY OF ENROLLEES.

SHARED OBJECTIVES

Objective II/3a-S: Develop detailed business and data requirements for the Consumer Registration and Enrollment System.

Indicator II/3a-S: A series of documents are prepared that depict in detail all the known business and data requirements to be used in the development of the Consumer Registration and Enrollment System. **Accomplished**.

Comparison: In SFY'93, only the basic goals and requirements for the Consumer Registration and Enrollment existed.

Narrative: In SFY'94, through work with a focus group, including DMH personnel, providers, consumers and other interested parties, the data and business requirements were documented using a structured methodology. The documents included data models, description of entities and relationships, process models and process definitions. Confidentiality issues were addressed in the focus groups and steering committee, both of which included consumer, provider and DMH Legal department representation. The issue of confidentiality is addressed as a major deliverable in the documentation for the Registration and Enrollment System.

Objective II/3b-S: Publish a Request for Proposals for the functional design and development of the system.

Indicator II/3b-S: A vendor contract to develop the system is approved. **Not accomplished.** (See Narrative below)

Comparison: In SFY'93, no mechanism to develop the system had been identified.

Narrative: Although extensive work was done in SFY'94 to complete the RFP, additional work was required. During SFY'94 several things occurred that affected the overall status of the project and prevented complete implementation of this objective. The Director of the Applied Information Technology group resigned and the process of hiring a project director took much longer than anticipated, again affecting the overall progress of the project. Despite these set backs, the Department was successful in meeting most of the objectives and an excellent foundation for the development of the RFP now exists.

Objective II/3c-S: Develop and begin to implement a detailed plan for the communications infrastructure required to support the system.

Indicator II/3c-S: A phased-in plan to provide communications between all Area offices and facilities is developed. **Accomplished**.

Comparison: In SFY'93 no plan existed.

Narrative: In SFY'94, a two phase plan was created. The first phase included attaching all Area administrative offices to the statewide Wide Area Network (WAN). The second phase will include all DMH facilities that are required to have access to the Consumer Registration and Enrollment System.

Objective II/3d-S: Complete the functional design for the system and begin development.

Indicators II/3d-S:

- Review responses to the RFP for the Consumer Registration and Enrollment System, choose a vendor and complete the functional design. **Not accomplished.**
- Form a project team in coordination with the vendor and develop the first stages of the actual programs for the Consumer Registration and Enrollment system. **Not accomplished**.

Comparison: In SFY'93 no plan or functional design existed and no vendor had been chosen.

Narrative: The complete implementation of this objective was dependent on the completion of Objective II/3b-S; Staff changes, as noted in Objective II/3b-S, created unavoidable delays.

REQUIREMENT #III: The State plan shall describe available services, available treatment options, and available resources (including Federal, State and local public services and resources and to the extent practicable, private services and resources) to be provided to individuals with a serious mental illness or emotional disturbance.

To enhance access to services, the Department has continued to focus on service integration for DMH consumers who are also Medicaid recipients, on developing appropriate staffing and programming for ethnic and minority populations and others requiring specialized services. The Department has continued to place a heavy emphasis on ensuring that consumers are aware of their human and legal rights and on ensuring that supporting structures are in place.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Increased Access to Services

GOAL III/1: COLLABORATE WITH THE DIVISION OF MEDICAL ASSISTANCE/MEDICAID (DMA) AND ITS VENDOR, MENTAL HEALTH MANAGEMENT OF AMERICA (MHMA), TO ASSURE MAXIMUM INTEGRATION AND COORDINATION OF SERVICES TO DMH PRIORITY CONSUMERS.

Objective III/1a-S: Complete development of emergency service data collection pilot projects in the DMH Northeast and Central Mass Areas. These projects will track client contacts with the emergency services system. Based on the outcome of these projects, commence statewide implementation of a standardized data base for designated emergency programs to monitor the flow of clients through the service system and provider compliance with standards of care.

Indicators III/1a-S:

- DMH Central Office collaborates with the Northeast and Central Mass Areas to develop and implement a pilot emergency service data tracking system. **Accomplished**.
- DMH Central Office works with other Areas and the DMH Applied Information Technology Division in planning for statewide implementation of a standardized data tracking mechanism. **Accomplished**.

Comparison: In SFY'93, no standardized emergency service tracking mechanism existed. In SFY'94, the DMH Director of Utilization Management collaborated with the Northeast and Central Mass. Areas to develop and implement a standardized emergency services tracking form that was consistent with the needs of the DMH Public Managed Care system. This data tracking system is currently in operation in these Areas.

Narrative: An evaluation of the Areas with systems in place has occurred and DMH is moving forward with a plan to develop and implement a standardized emergency services data tracking system for its entire system.

Objective III/1b-S: With DMA and its vendor, MHMA, and input from consumers, advocates and family members, develop a mechanism to use established adult clinical criteria and protocols and child/adolescent clinical protocols (when completed) to assess and evaluate the performance of Designated Emergency Programs (DEP).

Indicators III/1b-S:

- Utilization Management (UM) standards and practice guidelines are established. **Accomplished**.
- A statewide group meets to evaluate performance objectives. **Accomplished**.
- Child/adolescent clinical protocols are completed. **Accomplished**.
- Areas commence regular communications and meetings with MHMA to monitor and continually improve the provision of care to shared consumers. **Accomplished**.

Comparison: In SFY'93, no clinical protocols or UM standards existed. These were developed in SFY'94, enabling the desired interaction between MHMA and the Areas to occur.

Narrative: The UM standards and practice guidelines require DMH Areas, in collaboration with DMH Central Office, to work with DMA and its providers to develop integrated systems of care for consumers. This involves developing a process to monitor access to care, transfer of consumers between organizations and other quality and utilization issues as required by the Department. In

addition, the UM standards promulgated in SFY'94 provided the basis for each Area to develop mechanisms by which the quality of care delivered to shared consumers (DMH and DMA) is continually monitored.

Objective III/1c-S: Continue regular meetings with DMA (Medicaid) and its vendor, MHMA, to address consumer and family member concerns regarding access to and quality of care in MHMA network services.

Indicator III/1c-S: Meetings are held with DMA and its vendor, MHMA, to address consumer and family member concerns regarding access to and quality of care in MHMA inpatient network services. **Accomplished.**

Comparison: At the end of SFY'93, clinical criteria and protocols were promulgated to regulate the clinical interaction between DMH and MHMA regarding admissions, transfers and discharges. An ad hoc group was established, including the DMH Deputy Commissioner for Clinical and Professional Services (an M.D.), DMH UM Director (an M.S.W.), and two clinical nurse specialists from DMA and MHMA, to address issues of access and quality. The group met regularly during the first half of SFY'94 to address issues related to implementation of the protocols and then continued to meet on an "as needed basis" to resolve issues that could not be resolved at the local level.

Objective III/1d-S: Work with the Statewide Dual Diagnosis Task Force to develop a Resource Guide for Dual Diagnosis Services based on the DMH/DPH survey.

Indicator III/1d-S: The Statewide Dual Diagnosis Task Force develops a resource directory. **Not accomplished.** (See Narrative)

Comparison: In SFY'93, no resource guide existed.

Narrative: The Statewide Task Force felt that developing a resource guide was premature. Although the DMDH/DPH survey provided an opportunity for both DMH and DPH programs to self-identify as providers of services to the dually diagnosed, the group felt more work was needed before a directory could be published. The group, however, developed a "double trouble" self-help program list which was distributed through a DMH consumer newsletter.

CHILD ONLY OBJECTIVE

Objective III/1e-C: Complete development of child/adolescent clinical criteria and protocols governing DEP admissions to MHMA network hospitals and DMH inpatient units, and conduct appropriate training.

Indicator III/ 1e-C: Clinical criteria and protocols governing admissions to MHMA and DMH inpatient units are jointly developed and approved by DMH and MHMA. All DEP teams in the state, the MHMA inpatient providers, DMH inpatient providers and DMH child/adolescent staff are trained. The protocol is used by all DEPs in the state. **Accomplished**.

Comparison: In SFY'93 clinical criteria for hospital admission were not clearly defined and there was no common statewide protocol for use by teams screening hospital admissions.

Narrative: The development of clinical criteria and protocols for admission to MHMA network hospitals and DMH inpatient units has served to clarify the definition of acute care which is covered by MHMA and extended care which is the responsibility of DMH, and has served a utilization review function.

Objective III/1f-C: Discuss with DMA the feasibility of establishing a pilot project to provide training to primary care clinicians to enable them to better recognize mental health problems in children in order to make appropriate referrals.

Indicator III/ 1f-C: Discussions are held with DMA regarding the feasibility of establishing a pilot project. **Accomplished**.

Comparison: Through more explicit reference to mental health in Early & Periodic Screening, Diagnosis & Treatment (EPSDT) guidelines, and through assessment of current referral patterns, DMA took active steps in SFY'94 to ensure that primary care providers identify and refer children in need of mental health treatment.

Narrative: DMH participated in the development and review of new EPSDT guidelines to assure that they would facilitate recognition of mental health problems in children and promote referrals. In light of quality improvement activities being undertaken by DMA to assess access to mental health services, including review of referral patterns to EPSDT and development of new EPSDT protocols to be accompanied by provider training, it was agreed that a pilot project was not appropriate at this time.

GOAL III/2: CONTRACT FOR A SUFFICIENT NUMBER OF ACUTE AND CONTINUING CARE BEDS IN PRIVATE AND GENERAL HOSPITALS TO MEET THE NEEDS OF DMH CONSUMERS.

ADULT ONLY OBJECTIVE

Objective III/2a-A: In the Metro Boston Area: add 16-18 additional acute replacement beds to complete the statewide need for these contracted beds; re-evaluate the number of CMHC

beds to "rightsize" the number of available beds in the Area. CMHC-related actions include closure of the Massachusetts Mental Health Center's acute and continuing inpatient care (acute care is already provided at a general hospital, continuing care at a public health hospital) and the transfer of continuing care from the Dr. Solomon Carter Fuller Mental Health Center to the Lemuel Shattuck Public Health Hospital, Bay Cove MHC.

Indicator III/2a-A: A contract is signed for 16-18 additional acute replacement beds; a CMHC bed need review is completed; Massachusetts Mental Health Center is closed; continuing care is transferred from Dr. Solomon Carter Fuller Mental Health Center to the Lemuel Shattuck Public Health Hospital. **Not fully accomplished.**

Comparison: At the end of SFY'93, there were 175 acute replacement beds in operation across the state, including 42 in the Metro Boston Area (25 at Deaconess hospital and 17 at Cambridge Hospital). A determination regarding the number and final configuration of acute beds in the Metro Boston Area was dependent on the completion of the separate planning process in that Area, as described below. All objectives in III/2a-A were addressed in SFY'94 and will be fully implemented in SFY'95.

Narrative: It was determined that a consultant was needed to complete a statewide bed-need analysis, including the CMHC bed-need evaluation in Metro Boston. A consultant was hired, and the report will be completed in SFY'95 (December). After the study is completed, a decision will be made on the need for additional replacement beds in Metro Boston and, if warranted, a request for proposals will be issued. The Massachusetts Mental Health Center closure was delayed due to legislative action which prevented closure from taking place. The transfer of continuing care from the Dr. Solomon Carter Fuller Mental Health Center to the Shattuck Public Health Hospital has been delayed by renovation difficulties.

Objective III/2b-C: Continue to assess the need for continuing care inpatient beds for children and adolescents.

Indicator III/ 2b-C: Referrals for continuing care are processed on a regular basis, and waiting lists reviewed at least bi-weekly. **Accomplished**.

Comparison: The number of children requiring extended inpatient stays remains the same as in SFY'93. The resources are adequate to meet the demand.

Narrative: Although requests for extended inpatient treatment increased, analysis of the demand for services for both younger children and adolescents revealed that most of the children being referred did not require hospital level of care. Clinical review indicated that most needed ongoing care in a physically secure intensive residential program. The current capacity of intensive residential treatment programs is adequate to meet the needs of the latency age population. Sixteen additional beds for adolescents are expected to be brought on line in SFY'95, and the Secretary of EOHHS has agreed to support a budget request for those 16 beds plus an additional 8 beds in the SFY'96 budget.

Objective III/2c-C: Continue to assess the numerical adequacy of acute inpatient beds provided for uninsured children and adolescents through free care arrangements with private psychiatric hospitals.

Indicator III/ 2c-C: Free care usage is tracked on a daily basis by each Area, and by each hospital. Area and hospital data are aggregated in monthly reports and reviewed collectively by the Areas in a statewide meeting. DMH continues to meet with the Mass. Association of Private Psychiatric Health Services providers on an as needed basis to resolve problems related to free care. **Accomplished**.

Comparison: The demand for free care increased in SFY'94. DMH noted the trend, restructured the free care arrangement with the private psychiatric hospitals, and developed a plan for delegating responsibility for management of the free care beds to the Areas which was scheduled to go into effect at the beginning of SFY'95.

Narrative: DMH continues to monitor free care use and waiting time for hospital beds, in order to assess the adequacy of the new Area-based system to meet the demand. One New Hampshire hospital on the Massachusetts border has voluntarily contributed some free care. Also, additional funds were allocated to the DMH Western Mass. Area for purchase of hospital care for uninsured children, as there is no psychiatric hospital within the Area. Letters of understanding between each Area and the private psychiatric hospital which will provide it with free care will be signed by early fall, 1994. Monitoring the needs of uninsured youth remains an ongoing objective, however, as changes in policies and practices of DMH and DSS, as well as insurance changes and changes in eligibility for welfare payments and Medicaid, affect the number of children who are uninsured.

Access to Services for Special and Sub-Populations

GOAL III/3: ENSURE ACCESS TO SERVICES FOR SPECIAL AND SUB-POPULATIONS.

SHARED OBJECTIVES

Objective III/3a-S: Implement SFY'94 recommendations in the CCSS plans relative to special and sub-populations.

Indicator III/3a: Compliance is monitored through the annual CCSS review process which includes annual reassessment of met needs, and extensive consumer participation and comment. **Accomplished**.

Comparison: In SFY'93, CCSS plans included detailed demographic data from the DMH statewide needs assessment concerning the elderly, deaf and hard of hearing and racial and cultural minority groups, as well as data regarding substance abuse, physical illness or disability, living situation, employment status and functional level. No formal needs assessment survey of the child and adolescent population was conducted but demographic statistics indicate a growing minority population including large numbers of new immigrants and refugees. In SFY'94, services throughout the seven Areas were restructured, as appropriate, to expand services to special and sub-populations with no new dollars. Funding for new programs, when available, was distributed based on CCSS plan ratings.

Narrative: Each CCSS plan includes a required strategy for providing access to acute care, supportive services, rehabilitation, treatment, advocacy and generic community services for the DMH planning population, including racial, cultural and linguistic minorities, dually diagnosed (mental illness and substance abuse), elders and the homeless.

Mental Illness and Substance Abuse

Objective III/3b-S: Continue to implement the plan developed in June 1992 by the DMH and DPH commissioners to increase collaboration between the two agencies to enhance access for the dually-diagnosed population (mental illness/substance abuse). **Note: Other, specific objectives targeted to the dually diagnosed are already enumerated under Requirement II, pages 22-24.

Indicator III/3b-S: The plan is being implemented. Please see comments under Requirement II.

Objective III/3c-S: Continue to pursue new grants and implement existing grants from NIMH and National Institute on Drug Abuse regarding substance abuse among persons with serious mental illness (ongoing).

Indicator III/3c-S: The Department applies for appropriate competitive NIDA, NIAAA, and NIMH grants: **Accomplished.**

- NIDA Application: "Scales to Detect PTSD and Drug Abuse Among Seriously Mentally Disordered Persons. Submitted in FY'93; approved in FY'94. NIDA approved grant funds to begin in FY'95 for three years. 1 out of 20 grants submitted to NIDA are funded.
- NIAA Application: "Scales to Detect PTSD and Alcohol Abuse Among Seriously Mentally Disordered Persons. Submitted in FY'93; approved in FY'94. Not funded.

Comparison: The Department has been continuously funded for research on dual diagnosis (primarily treatment strategies/outcome) since 1987.

Narrative: Information gained in past studies is further developed for integration into ongoing programs and training (see, for example, Objective II/2h-A) and is used to inform policy development.

Objective III/3d-S: Continue maintenance of effort of 1993 goal to establish a mechanism to monitor operations of contracting agencies to ensure that the cultural and linguistic needs of DMH priority consumers are being met. Endeavor to increase participation of vendors in the monitoring function.

Indicators III/3d-S:

- All vendors complete contract pre-qualification questionnaires which are designed to assess the capacity of these service providers to meet the special needs of cultural and linguistic minorities and individuals who are physically challenged. **Accomplished.**
- Information submitted by the providers informs the Department as to the status of accessibility of programs and facilities to all consumers. **Accomplished.**

Comparison: A mechanism was established in SFY'93 to monitor operations of contracting agencies. The SFY'94 goal required maintenance of effort. In SFY'94, this effort was continued and vendor participation increased.

Narrative: Essential monitoring activities are carried out by oversight of the contract award process, and reporting by vendors of corrective actions taken by contractors providing goods and services to programs and facilities serving DMH consumers. In the course of the contract award process, assigned DMH staff review the RFPs and assess the contract proposals of bidders to determine whether or not the requirements of this goal are being met.

Objective III/3e-S: Sustain the 1993 implementation effort to review DMH regulations, operational policies and practices, and review all Requests for Proposals, to ensure compliance with the Americans with Disabilities Act of 1990. Expand the effort to increase involvement and participation in all DMH Areas. Provide statewide ADA training to vendor contractors.

Indicators III/3e-S:

- A comprehensive review of DMH regulations, operational policies and practices is completed under the aegis of the DMH EEO/AA Office. **Accomplished**.
- Three Assistant EEO/AA Administrators are assigned to participate in the review of Requests for Proposals, including interviews of qualified bidders competing for contract awards. **Accomplished**.
- ADA training is provided to vendors. **Partially accomplished**.

Comparison: In SFY'93, ADA training was begun and ADA program functions were partially implemented at the Area level. SFY'94 accomplishments included establishing ADA program functions in all Areas and completion of ADA training for DMH personnel and a number of vendors.

Narrative: Training could not be provided to all vendors because of the large number of new contract awards, and demands on staff time as a result of the DMH initiative to implement a single residential code for all community-based facilities and the need to provide training to newly hired personnel.

Objective III/3f-S: Assess the need for translation of written documents (Office of Multi-Cultural Services/Refugee Assistance Program - OMCS/RAP); focus on materials that are standardized across DMH Areas and can therefore be distributed on a statewide basis.

Indicators III/3f-S:

- OMCS/RAP identifies and works with key individuals in DMH to coordinate and streamline task. **Accomplished**.
- OMCS/RAP identifies and works with appropriate translators to ensure quality of product and determines financial feasibility of work to be undertaken. **Accomplished**.

Comparison: In SFY'93, no such plan for document translation existed.

Narrative: Linkages were established with human rights officers at all state facilities through the DMH Special Assistant for Human Rights. Other statewide

initiatives included translations of documents related to DMH HIV/AIDS policy. Requests for translation of materials from specific facilities and programs were also reviewed and granted. Implementation of this objective is on-going.

ADULT ONLY OBJECTIVES

Elders

Objective III/3g-A: Continue to ensure that emergency service workers, case managers, homecare providers, nursing homes and hospitals receive appropriate consultation and training regarding services for elderly consumers.

Indicator III/3g-A: Providers who come in contact with elderly consumers are targeted for attendance at the regional gerontological training conferences planned by DMH (see Objective II/3k-A). **Accomplished**.

Comparison: No conferences were held in SFY'93. Two of four planned training conferences on the Unique Needs of Elderly Mentally Ill were held in SFY'94 and emergency service workers, case managers, homecare providers, nursing homes, and hospital employees were targeted for attendance. The two remaining conferences are scheduled for SFY'95.

Narrative: In addition to the above referenced training conferences, planning took place to initiate a "train the trainer" series for homecare corporation employees and peer counselors, to be held in SFY'95.

Objective III/3h-A: Continue to reduce the overall number of medically ill/mentally ill individuals (MI/MI) residing in state facilities.

Indicator III/3h-A: The number of medically ill/mentally ill individuals residing in state facilities is reduced. There are regular meetings of MI/MI coordinators to assist in placement. **Accomplished**.

Comparison: At the end of SFY'93, 7% of the individuals residing in state hospitals were MI/MIs; at the end of SFY'94, the percentage was 3%.

Narrative: The Department has been very successful in reducing the number of MI/MIs in state facilities. The majority of these individuals are placed in skilled nursing facilities as they have medical issues. Information is provided to the state facilities about more appropriate placements.

CHILD ONLY OBJECTIVES

Objective III/3i-C: Implement the federal grant to train mental health workers concerning special issues of adopted children and their families.

Indicator III/3i-C: Staff at four intensive residential treatment programs for adolescents, at one intensive residential treatment program for children, and staff at the three inpatient units serving adolescents all participate in three-part adoption sensitivity trainings held at their sites. **Accomplished**.

Comparison: For most of the staff, SFY'94 was the first time they had ever received training about the special issues faced by adoptive children, and about the adoption possibilities for severely emotionally disturbed children.

Narrative: The trainings were very well received, as indicated by positive feedback on the evaluation forms and letters received from program and clinical directors. An average of 11 staff participated in each training session at each site. Based on evaluation feedback, the trainings are being slightly modified to hone in on topics of most concern to staff. The trainings were videotaped for use in future staff orientation. Trainings of additional clinicians are scheduled for SFY'95.

Objective III/3j-C: Establish home-based crisis intervention services to address the special needs of adopted children with mental health problems.

Indicator III/3j-C: Families with adopted children at risk of psychiatric hospitalization receive intensive home based treatment from two social workers trained both in the Homebuilders model and in adoption issues. **Accomplished**.

Comparison: No such services were available to adoptive families with seriously emotionally disturbed children in SFY'93, unless they were involved with DSS. Sixteen families received these services in SFY'94.

Narrative: The program has operated at full capacity since its inception. Referrals are made through the Designated Emergency Programs or through the DMH Area Office. All but one of the children continued to reside at home at the end of the intervention.

Objective III/3k-C: Complete the ongoing interagency assessment of the juvenile sex offender population and begin to develop service approaches.

Indicator III/3k-C: The assessment is completed and a report is issued. The report addresses systemic issues and includes specific recommendations for improving the Commonwealth's response. **Accomplished.**

Comparison: This was the first system-wide look at children being treated or cared for by the Commonwealth.

Narrative: The report, "The Massachusetts Department of Mental Health Point in Time Survey of Sexually Abusive Children and Youth," issued in August/ September 1993, provided the hard data necessary for the agencies to formulate a response. In addition, a proposal is being formulated for a specialized residential treatment program for sexually abusive youth, which will be presented to the Executive Office of Health and Human Services for its consideration. A major conference on current research and training practices in dealing with sexually abusive youth is planned for November 1994.

Forensically Involved Consumers

GOAL III/4: ENHANCE THE CLINICAL CAPACITY OF THE DEPARTMENT TO EVALUATE AND TREAT FORENSIC PATIENTS AND MAKE THE DEPARTMENT MORE RESPONSIVE TO THE NEEDS OF INDIVIDUALS WITH MENTAL ILLNESS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM.

SHARED OBJECTIVE:

Objective III/4a-S: Refine the clinical consultation capacity.

Indicator III/4a-S: Monthly forensic data yield hard numbers regarding the number of evaluations performed and the length of time taken to complete the process. **Accomplished, although monitoring continues.**

Comparison: Prior to SFY'94, DMH was unable to complete many of the forensic clinical consultations in a timely manner; consequently, decisions regarding patient privileges and discharges were delayed.

Narrative: During SFY'94, the forensic division refined and more narrowly focused the clinical consultation process involving the inpatient forensic population. Senior level forensic administrators and Designated Forensic Professional (DFP) staff were assigned to work cooperatively with hospital administrators and clinical staff to develop a more efficient and effective evaluation process which would not impose unreasonable timelines or delays on either the patient or the facility.

The modified clinical consultation process, although fully operational, will continue to be monitored during SFY'95 to better reflect a system of shared risk assessment and management with facility-based treatment teams. The modified

process will allow the forensic consultations to focus more specifically on a smaller and potentially more dangerous patient population.

During SFY'93, the first year of the consultation process, 26% of the evaluations took longer to complete than the established guidelines allowed. During SFY'94, only 10.8% of the consultations exceeded the established timelines. From the beginning of the consultation process to the end of SFY'94, there was an 86% improvement rate in timely completion of forensic consultations.

ADULT ONLY OBJECTIVES:

Objective III/4b-A: Develop an informed system of risk assessment and management in the DMH inpatient system.

Indicator III/4b-A: Implement initiatives such as clinical consultation, that will enable the division to engage in activities that are central to the concerns of the Deaprtment's inpatient system. **Accomplished**.

Comparison: In SFY'93, the forensic division only interacted sporadically with the Areas and inpatient facilities regarding matters of risk assessment and the management of dangerous behaviors in the patient population.

Narrative: During SFY'94, the division provided Area and facility-based staff with a formal consultation mechanism to address the issues of risk assessment and management, and provided specialized training on violence and dangerousness to inpatient personnel.

The forensic inventory and data base has allowed DMH to make more accurate assessments of the numbers and types of patients committed to its inpatient service system under the forensic sections of MGL c.123. The outcome is a closer working relationship between the forensic specialists and the treating physicians and treatment teams, assuring a standard of forensic care and mental health treatment in line with national expectations.

Objective III/4c-A: Provide training and consultation to the inpatient service system regarding civilly committed patients who present possible issues of risk to public safety.

Indicator III/4c-A: Work with the Area Directors and chief operating officers to identify the training needs of clinical and administrative Area-based staff which are appropriate for the forensic division to provide. **Accomplished**.

Comparison: Before SFY'94, Area and inpatient staff had only infrequent access to training and consultation from forensic clinicians regarding issues of dangerousness and patient forensic concerns. In SFY'94, both administrative and clinical staff from the forensic division conducted case conferences and

training sessions at the state hospitals and CMHCs to discuss issues of patient behavior, violence and management with the treating staff.

Objective III/4d-A: Develop and submit legislation for a conditional release system and prepare the community mental health system for a conditional release initiative; involve consumers and advocates in the process.

Indicator III/4d-A: Work with personnel from the Middlesex County District Attorney's office, members of the Judiciary and Governor Weld's office to develop legislation for a program of conditional release. **Accomplished**.

Comparison: Efforts to develop a program of conditional release for Massachusetts were not undertaken in a substantive way until SFY'94.

Narrative: A program of conditional release would extend specialized mental health services to certain categories of forensic patients discharged into the community. In SFY'94, the Department examined all major national models and made suggestions to the Governor's office regarding the model DMH felt was best suited to the needs of the Massachusetts forensic patient population. A number of national experts met with local forensic mental health staff to assess the clinical, legal and political ramifications of such a program in this state. Efforts to introduce legislation to support conditional release are ongoing, and closure is expected within the next fiscal year.

The Department intends to submit legislation for a program of conditional release during the next legislative session (1995), and will advocate in conjunction with the Judiciary, district attorneys, governor's office and other interested parties for its passage. Additionally, the forensic division will work with the Area Directors, advocates and consumers to prepare the community for the conditional release program.

Objective III/4e-A: Develop forensic (secure) inpatient regulations.

Indicator III/4e-A: Examine JCAHO forensic evaluation standards and establish a committee comprised of DMH hospital administrators, clinical treatment staff, legal staff, vendor staff working within the Secure Care Program at Taunton State Hospital, and human rights staff to address the issues of forensic inpatient regulations for the population requiring a higher level of security than civilly committed patients. **Accomplished**.

Comparison: There was no organized effort to examine the need for specialized secure inpatient regulations in SFY'93.

Narrative: The development of secure in-patient regulations is an activity DMH has been pursuing vigorously and will complete in SFY'95. A DMH

attorney was assigned to the forensic division in SFY'94 to attend to matters that are specifically forensic, including policy development.

The previously referenced committee, chaired by the forensic attorney, met during SFY'94, evaluated the need for secure inpatient regulations and developed a set of recommendations. The recommendations were organized and **will be** submitted to the Department's Policy and Planning Committee for review and comment prior to review and approval by the Commissioner and Executive Staff as DMH policy.

Objective III/4f-A: Continue to support the plan to transfer clinical and treatment responsibility at the Bridgewater Treatment Center to a private vendor.

Indicator III/4f-A: Develop a Request for Proposals to privatize clinical and treatment services at the Massachusetts Treatment Center, and award contracts for service delivery to private vendors. **Accomplished**.

Comparison: Prior to SFY'94, all aspects of clinical and treatment service delivery at the Treatment Center were provided by state employees.

Narrative: DMH has completed the process of privatizing clinical and treatment services at the Massachusetts Treatment Center for the Sexually Dangerous. Contract awards were made to two not-for-profit corporations, Justice Resource Institute and Psychological Services, Inc.

Objective III/4g-A: Subject to legislation passing during the 1994 session and modification of existing consent decrees, transfer the Bridgewater Treatment Center from the Department of Mental Health to the Department of Correction.

Indicator III/4g-A: Pass legislation during the 1994 legislative session to transfer the Massachusetts Treatment Center from the Department of Mental Health to the Department of Correction (DOC). **Accomplished**.

Comparison: Prior to the 1994 legislative session, the Department of Mental Health was responsible for all aspects of the operation the Center except security.

Narrative: The Department of Mental Health is currently waiting for the decision of the federal court regarding modification of the federal consent decrees which are necessary to effect a transfer of the facility to the DOC.

Objective III/4h-A: Maintain DMH presence in county correctional facilities.

Indicator III/4h-A: DMH maintains a clinical staff presence in the Essex, Norfolk, Worcester, Berkshire, Hampshire, Franklin and Plymouth Houses of Correction and in the Suffolk jail, and provides mental health services to inmates in these facilities who otherwise would be seeking admission to the DMH in-patient system via GL c.123 §18a. **Accomplished**.

Comparison: During SFY'94, DMH expanded its presence to the Hampden County House of Correction, through a contract with Behavioral Health Network. The contract is intended to provide clinical evaluation and treatment services to men and women who are awaiting trial or sentenced from the Commonwealth's western counties. DMH continued to maintain a presence at the other county correctional facilities.

Narrative: The effectiveness of the county corrections-based services can be measured by noting the steady decrease in the numbers of c.123§18a commitments to DMH inpatient facilities or to Bridgewater State Hospital. Without these on-site mental health services, inmates who experience mental health crises would be seeking admission to mental health facilities in far greater numbers.

CHILD ONLY OBJECTIVE:

Objective III/4i-C: Use DMH forensic consultants to conduct evaluations on inpatient units for children and adolescents.

Indicator III/4i-C: Designated Forensic Professionals (DFPs) conduct evaluations on inpatient units for children and adolescents. The DFPs concentrate on those juvenile inpatients most in need of assessment and complete evaluations in a shorter time, as documented by the forensic division data base. **Accomplished**.

Comparison: In SFY'93, DMH was not able to provide specialized, timely juvenile clinical consults. In SFY'94, as a result of newly developed, more focused guidelines that identify a narrower range of individuals appropriate for clinical review, the DFPs conducted fewer evaluations, but were able to concentrate on those juveniles most in need of assessment. The decreased numbers also resulted in evaluations completed in shorter time frames, eliminating unnecessary delays in making decisions regarding privileges or discharge.

Narrative: DFPs who are child and adolescent specialists were assigned to provide clinical consultation to juveniles in the inpatient system. This resulted in more specialized forensic evaluations performed in a more timely manner.

Objective III/4j-C: Conduct risk assessments of individuals in inpatient units and Intensive Residential Treatment Programs (IRTPs) to promote appropriate discharge planning.

Indicator III/4j-C: The forensic consultation teams are available to the IRTPs and inpatient units and conduct all requested risk assessments. **Accomplished.**

Comparison: A better, more formalized system for assuring that forensic evaluations are conducted is now in place. This was not true in SFY'93.

Narrative: Forensic staff are linked to children's services staff to assure that appropriate services are delivered. This linkage takes place at the court clinic level where attempts are made to prevent unnecessary hospitalization as well as on the units once a child or adolescent is placed.

Objective III/4k-C: Provide consultation to staff of inpatient units and IRTPs regarding new treatment approaches for children and adolescents not responding to existing treatment plans.

Indicator III/4k-C: Information and consultation on treatment approaches is provided to inpatient units and the IRTPs through the centralized clinical consultation team, including a child psychologist and a child psychiatrist specializing in psychopharmocology who visit each program on a regular schedule. **Accomplished.**

Comparison: This is the continuation of a clinical consultation initiative in place in SFY'93.

Narrative: The clinical consultation team recommended that DMH institute a formal utilization management system to assure that each child is receiving the level of care he or she needs, and that children move to the next level of care as soon as clinically appropriate. This UM program will be instituted in SFY'95.

Protection and Advocacy

GOAL III/5: ENSURE THAT CONSUMERS ARE AWARE OF AND AFFORDED THEIR HUMAN AND LEGAL RIGHTS, INCLUDING ACCESS TO LEGAL ADVOCACY SERVICES, IN ALL FACILITIES AND PROGRAMS OPERATED OR FUNDED BY THE DEPARTMENT.

Objective III/5a-S: Ensure that consumers are aware of and afforded their human and legal rights in all facilities and programs

funded by DMH, including contracted community service programs and privatized acute replacement units.

Indicators III/5a-S:

- DMH has human rights officers and human rights committees for its contracted programs to advise consumers of their rights and ensure compliance with rights. **Accomplished**.
- DMH visits each privatized acute replacement unit to review human rights postings, reviews human rights information that goes to consumers, and meets with the human rights officer (HRO) to ensure that the HRO understands and is performing his/her responsibilities. **Accomplished**.

Comparison: By the end of SFY'93, DMH had not completed these tasks. The tasks were completed in SFY'94.

Narrative: The meetings with the privatized inpatient programs were completed in SFY'94 and helped ensure that these units understood and were implementing the human rights policy. The objective was accomplished but it is an on-going process of monitoring to ensure that consumers understand their rights and that human rights policies are implemented.

Objective III/5b-S: Ensure that consumers and legal guardians in community-based programs and replacement units are aware of their human and legal rights, including the right to file a complaint under the Department's regulations (104 CMR 24.00) or, in acute replacement units, as provided for in the standard contract.

Indicators III/5b-S:

- The Department trains HROs and other staff in these programs to understand consumers' rights so that the HROs and other staff can ensure that consumers and legal guardians understand their rights, including the right to file a complaint. **Accomplished**.
- The Department prepares and distributes written materials to the HROs and other staff explaining the rights of consumers and how consumers and legal guardians can file complaints. **Accomplished**.

Comparison: This is an on-going process, and the work done in SFY'93 was repeated in SFY'94 to ensure continued compliance and to ensure that consumers (and their legal guardians) understand consumers' rights.

Narrative: Comprehensive training materials were prepared and distributed, and training conferences and a human rights conference were held.

Objective III/5c-S: Ensure that consumers are aware of the availability of assistance from independent legal advocacy programs, including the Center for Public Representation's Protection and Advocacy Program for Individuals with Mental Illness (CPR) and the Mental Health Legal Advisors Committee (MHLAC).

Indicators III/5c-S:

- The Department includes in its written training materials, which are distributed to human rights officers, consumers and their guardians, information about the availability of free legal advocacy assistance, including MHLAC and CPR programs. **Accomplished**.
- The Department ensures that in its operated and funded facilities, organizations available to provide legal advocacy are permitted to post a notice of availability of assistance and are allowed to come to the facility to advise consumers of their availability. **Accomplished**.

Comparison: This is an on-going process, although the negotiations to ensure availability were completed in SFY'94.

Narrative: Negotiations were successful in all DMH-funded replacement units to allow access by legal advocacy programs so that, even without a specific request for assistance, legal advocates could advise consumers of the availability of legal advocacy services. Training materials listing the names, addresses and phone numbers of the legal advocates' organizations were distributed. The process of keeping consumers aware of the availability of this assistance is on-going.

Objective III/5d-S: Continue to support the independent Citizen Monitoring Project in state operated inpatient facilities provided in conjunction with the Alliance for the Mentally Ill of Massachusetts as well as other independent citizen monitoring programs in DMH replacement units in private and general hospitals.

Indicator III/5d-S: The two DMH acute inpatient replacement units for adults and the three Gaebler replacement units for children that come on-line in SFY'94 initiate citizen monitoring programs. **Accomplished**.

Comparison: Citizen monitoring activities were expanded by five to include the replacement units that came on-line in SFY'94.

GOAL III/6: CONTINUE TO IMPLEMENT STRUCTURAL CHANGES IN THE OFFICE OF INTERNAL AFFAIRS (OIA) THAT PROTECT THE

LEGAL AND HUMAN RIGHTS OF CONSUMERS AND ENSURE ACCOUNTABILITY ON THE PART OF DMH.

SHARED OBJECTIVES

Objective III/6a-S: Formalize the liaisons with DMH Licensing, Labor Relations and Human Resources to develop a formal process of auditing Decision letters and their results.

Indicator III/6a-S: The DMH Licensing division now receives copies of investigation reports and decision letters, as well as MGL Chapter 19C (Disabled Persons Protection Commission) applications for intake and reports on all matters pertaining to facilities licensed by DMH. Matters concerning potential employee disciplinary action are brought to the attention of Human Resources at the Area level by OIA Investigations Managers. **Accomplished**.

Comparison: A formal system of communication was not in place before SFY'94.

Narrative: The Deputy Commissioner for Program Operations issued guidelines for the content of decision letters, requiring that each letter not only include specific findings, but also direct specific corrective action, assignment of responsibility for such action and time frame for completion. The content of decision letters is monitored by the Deputy Commissioner via the appeals process.

Objective III/6b-S: Determine how best to present, distribute and utilize data from OIA monthly report based on reports received by OIA via the DMH critical communications policy. Specifically, determine whether a similar or parallel report based on complaints filed, as opposed to incidents reported, would be of value.

Indicator III/6b-S: An analysis of the content and usefulness of the monthly OIA report is conducted, and recommended changes are implemented. **Accomplished**.

Comparison: The OIA report content was changed in SFY'94.

Narrative: The OIA monthly report format has been changed, in order to provide more useful information. The report includes data pertaining to critical incidents, presented by type, date, Area and service location. Since percentages are now used (percentages of each type of incident/per census/per location), valid comparisons are now possible among service locations within Areas; and among Areas. These reports are distributed to: Commissioner, Chief of Staff; Deputy Commissioner for Program Operations (who distributes them to

Area Directors); Deputy Commissioner for Clinical and Professional Services (who distributes them to Area Medical Directors and QM personnel); General Counsel. It was decided that a statistical review of complaints filed, in a format similar to that used with critical incident reports, would be included in each monthly report.

Objective III/6c-S: Address personnel shortages in OIA to remedy handling of complaints in a timely manner.

Indicator III/6c-S: Personnel shortages in OIA are addressed so that complaints are handled in a timely manner. **Accomplished**.

Comparison: In SFY'93, there were personnel shortages within OIA. By the end of SFY'94, all authorized investigator positions within OIA were filled.

Narrative: Since the latter part of SFY'94, a task force has been meeting to address implementation of placement within OIA of a number of full time field investigators adequate to conduct investigations in a timely manner. This group also has been addressing amendment of DMH regulation (104 CMR 24:00) to provide for a more efficient and responsive complaint and investigation process. The complex nature of the task has caused some delay in finalizing both the personnel issues and proposed regulatory amendments, but the process is slated for completion by the end of calendar year 1994.

Objective III/6d-S: Further professionalize the investigative function of the OIA within DMH.

Indicator III/6d-S: The investigative function of OIA is further professionalized by ensuring adequate staffing and providing additional training. **Accomplished**.

Narrative: A result of the work of the task force referenced in Objectives 111/6c and 6e to increase the size of the full time investigative force within the Office of Internal Affairs is that full time investigators will have the professional background to conduct investigations, and their sole focus on investigations will allow them to have time within their work schedules to receive investigative supervision and receive additional training. In June 1994, seven OIA staff members attended a three day conference on emergency psychiatry, and training on sexual abuse investigations for all investigative personnel is planned for SFY'95. Training of OIA staff continues to be a priority for the Department.

Objective III/6e-S: Review DMH regulations (104 CMR 24:00) regarding the Department's complaint and investigations procedures.

Indicator III/6e-S: A task force meets regularly to review DMH regulations regarding the Department's complaint and investigations procedures. **Accomplished**.

Narrative: Please refer to Objective III/6c (Narrative) for information on work of task force. By the end of SFY'94, the task force was preparing their recommendations to the Policy and Planning Committee, which will review them during SFY'95.

CHILD ONLY OBJECTIVE

Objective III/6f-S: Recommend process and implementation steps, within the constraints of personnel limitations, for the takeover by OIA of responsibility for the investigative functions now performed by the Child/Adolescent division regarding complaints in child and adolescent programs serving a statewide population, such as inpatient units and IRTPs.

Indicator III/6f-S: Responsibility for investigative functions regarding complaints in child and adolescent programs serving a statewide population are assumed by OIA. **Accomplished.**

Comparison: In SFY'93, OIA was not responsible for child/adolescent investigative functions. This responsibility was assumed by OIA in SFY'94.

Narrative: Transferring the responsibility for investigations to OIA from the Child/Adolescent division removed the possibility for conflict of interest, since child/adolescent staff are also responsible for ongoing clinical and administrative monitoring of these programs.

REQUIREMENT #IV: The State plan shall describe health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to adults and children with serious mental illness or emotional disturbance with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The establishment of Comprehensive Community Support Systems, the basis of the Department's system of Public Managed Care, has required that linkages be established and maintained with a wide variety of services that enable consumers to have their needs met in the community. Housing, health care and employment services have been key areas of focus. In addition, the Department has needed to establish an array of community-based services for children under age 14 who might previously have been served at the Gaebler Children's Center (now closed). An array of services was needed to promote interagency coordination for children being served in the community, and to develop mechanisms to ensure that parents and children's case managers had the training necessary to advocate for community services.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Extent and Availability of Services

GOAL IV/1: PLAN FOR, DEVELOP, MAINTAIN OR CREATE LINKAGE AMONG A SUFFICIENT NUMBER AND ARRAY OF SERVICES TO ENABLE CONSUMERS TO REMAIN IN THE COMMUNITY IN THE LEAST RESTRICTIVE AND MOST NORMALIZED SETTINGS.

SHARED OBJECTIVES

Objective IV/1a-S: Assure that final multi-year CCSS plans address the need for an integrated service system that includes health, rehabilitation, employment, residential and educational services and other community supports.

Indicator IV/1a-S: The CCSS review process documents service deficiencies, specifies corrective action plans and monitors compliance. **Accomplished.**

Comparison: In SFY'93, the first CCSS plans for six of the seven Areas followed a standard planning format and included a narrative that explained the basis and rationale for planned change. In SFY'94, the CCSS three year plans for SFY'95, '96 and '97 for all seven Areas again followed a standard planning format, and included corrective action plans developed to address service deficiencies noted in earlier documents.

Narrative: Each CCSS plan includes a required strategy for ensuring access to the five CCSS components (acute care, supportive services, rehabilitation, treatment, advocacy and generic community services) that incorporate health, employment, residential and educational services.

Objective IV/1b-S: Work with DMA to ensure that DMH adult and child consumers are appropriately assigned to and receive general medical services from health maintenance organizations or primary care clinicians as part of Medicaid's managed care (medical) waiver program.

Indicator IV/1b-S: DMH and DMA collaborate to appropriately assist Medicaid recipients who are also DMH priority consumers to enroll in HMOs or choose primary care clinicians for their general medical care as part of DMA's managed care waiver program. **Accomplished**.

Comparison: DMH and DMA have collaborated for several years to assist DMH priority consumers in selecting HMOs or primary care clinicians. This is an ongoing process.

Narrative: As of fall 1993, only the Medicaid recipient group federally defined as "disabled" - about 50,000 people - was still unenrolled in the waiver program. Thirty thousand people from this group did not respond to a mailing from DMA to encourage voluntary enrollment, and remained unenrolled. DMA had no specific indicators for type of disability and sought to obtain information on those with psychiatric disabilities, including personal addresses, from DMH through a data match. Due to concerns regarding confidentiality, DMH was not able to respond. DMA has continued to do outreach to this group of disabled recipients and will ultimately assign them to primary care clinicians, using past billing/provider information where available, if they fail to respond to DMA requests. DMH case managers have attempted to assist individual consumers with enrollment and Area Directors have attempted to encourage primary care physicians in their Areas who accept psychiatrically disabled patients to enlist in the PCP program.

Objective IV/1c-S: Reassess the employment services delivery system and assess the benefit of creating a single comprehensive employment program code to facilitate contracting and reimbursement for a range of employment services.

Indicators IV/1c-S:

- *Assessment* - Obtain consumers' comments about available vocational services during meetings held to develop standards for day/evening programs; hold internal meetings and meetings with program contractors, to discuss the effectiveness of the contracted employment services delivery system; compile data about the number and type of employment contracts for analysis. **Accomplished**
- *Standards development* - Develop standards for a vocational program that includes all vocational services under one program code; present standards to Executive Staff for approval. **Accomplished**.

Comparison: In SFY'93, there were various program codes for vocational services. Three program codes were identified as covering the majority of the Department's employment services contracts. These codes are still in place. However, standards were developed during SFY'94 that provide the foundation for the development of a single employment program code, subject to Executive Staff approval and the development of an implementation plan.

Narrative: Executive Staff proposed that standards be rewritten to include a stronger linkage to generic services when feasible and possible. DMH is working toward coordinating its service delivery system with the Mass. Rehabilitation Commission and Department of Employment and Training. The three agencies are collaborating to eliminate needless duplication of services. A stronger emphasis on competitive community employment is also being encouraged.

Objective IV/1d-S: Develop and implement a single program code for adult residential services and a single code for child/ adolescent residential services. These comprehensive codes would encompass generic components of residential services and allow for greater flexibility of evolving residential models, consistent with recommendations in the CCSS plans.

Indicator IV/1d-S: Single residential program codes for adult and child services are developed. **Accomplished**. (See Objective I/2d-S, page 24). Implementation will begin in SFY'95, when residential programs come up for contract renewal.

Objective IV/1e-S: As an outcome of the CCSS planning process, develop a strategic plan in each Area to address the needs of older adolescents who will continue to need mental health services as young adults.

Indicator IV/1e-S: Each Area submits a plan to address transition of older adolescents to the adult mental health systems (winter, 1994). Areas that do not adequately address this issue submit corrective action plans. **Accomplished**.

Comparison: Greater attention has been paid to the service needs of this population than in previous years.

Narrative: Youth with the most severe mental health needs receive services, as they are either taken on by the adult system or continue to be served by the children's system, but additional services are needed. Full implementation of the Area's strategic plans are dependent on funding, as new program models are needed to meet the needs of this transitional age group in the most age-

appropriate manner. One of the most difficult groups to plan for continues to be those youth who were served by the children's mental health system, do not meet the eligibility criteria for adult services and yet are incapable of living independently without a great deal of support. This is often also the group with the least access to entitlements.

ADULT ONLY OBJECTIVES

Objective IV/1f-A: Bring on line approximately 517 new units of housing. Of that number, 162 will support the continued consolidation of facilities in the Merrimack Valley and in the Metro Boston Area. There will be 40 additional beds developed with local housing authorities using funds from the state's Chapter 689 program. The remaining 315 units will be targeted for the homeless mentally ill (HMI). (The number of HMI units is dependent on funding through several pending federal applications. Federal funds would leverage $3.3 million appropriated by the state budget for this purpose.)

Indicators IV/1f-A:

- DMH creates at least 517 new units of housing by the end of SFY'94. **Accomplished**.
- DMH participates in several successful applications to the Department of HUD, securing federal dollars for housing. **Accomplished**.
- The legislature appropriates $3.3 million to be used for serving homeless persons with mental illness during SFY'94, in conjunction with leveraged HUD McKinney Act rental assistance or other HUD funds whenever feasible. **Accomplished**.
- The Merrimack Valley CCSS successfully downsizes inpatient operations, moving consumers into the new housing developed in the community. **Accomplished**.

Comparison: Through the end of SFY'94, DMH added 591 units of housing to its inventory, bringing the total to 4,541 units. At the end of SFY'93, there were 3,950 units recorded and DMH had not received the HUD or state funds to support the development of new housing units. In SFY'94, the value of the federal housing dollars secured for DMH consumers, including the homeless, was more than $12 million over the term of the grants.

Narrative: DMH pursued the development of new housing units through a combination of federal grants and state appropriations. The federal resources resulted from partnerships DMH formed around federal applications submitted by housing authorities, non-profit community groups and municipalities. DMH also collaborates with local housing authorities in using state housing programs to produce consumer housing.

Objective IV/1g-A: Maintain funding for and access to *clozapine* for all consumers who meet the clinical criteria, enabling them to function independently in the community rather than in long-term hospital or other similarly restrictive settings. Follow through with outcome study, pending funding through the Sandoz Pharmaceutical Company.

Indicators IV/1g-A:

- Consumers have access to the most current and efficacious psychiatric drugs. **Accomplished**.
- Funding from Sandoz for a *clozapine* outcome study, in collaboration with Northeastern University, is approved. **Accomplished**.

Comparison: In SFY'93 there were approximately 1,600 consumers receiving *clozapine*. Access to *clozapine* and other drugs increased in SFY'94.

Narrative: During SFY'94, *clozapine* use was expanded and was found useful in treating bipolar disorder in consumers who had not responded to traditional treatment. DMH is also funding research to treat "first break" schizophrenics with *clozapine*. During this period, other drugs were released that appear as effective as *clozapine* but do not cause agranulocytosis. In April 1993, *risperidone* was approved for treatment of psychiatric illness. It is less expensive and has fewer side effects than *clozapine* and does not require weekly blood monitoring. Many consumers anxiously awaited its release and opted for *risperidone* trials. DMH is tracking all patients initiated on both drugs in state facilities and will generate data to conduct a cost-benefit analysis.

Although the funding from Sandoz for outcome studies was approved, money has not yet been received.

Objective IV/1h-A: Continue implementation of the federal grant in the Central Mass. Area through a successful coalition, including the Mass. Rehabilitation Commission, DMH Area office, DMH-funded clubhouse, a day program of a local CMHC and a local college, to provide advanced employment opportunities for people with mental illness.

Indicator IV/1h-A: Fifteen to twenty consumers are placed in advanced employment opportunities. **Accomplished**.

Comparison: This collaboration started operating in January 1993. From January through June 1993, four consumers were placed in advanced employment opportunities. In SFY'94, twenty-four consumers were similarly placed.

Narrative: The keys to the success of this effort are:

- services provided as a result of the collaboration are entirely driven by the needs and preferences of the individual consumers being served;
- consumers' initial needs are met to accomplish the goal of advanced employment opportunity, and ongoing support is provided post-placement;
- collaboration takes place among the involved organizations;
- services are designed to complement rather than duplicate each other across agencies;
- non-mental health agencies are involved and share resources.

New Service Programs

GOAL IV/2: COLLABORATE WITH OTHER PUBLIC AND PRIVATE AGENCIES TO COORDINATE AND IMPROVE DELIVERY OF SERVICES TO DMH CONSUMERS.

CHILD ONLY OBJECTIVES

Objective IV/2a-C: Develop models for early intervention and comprehensive service delivery, including a single case management system, integrated intake, linkage with Medicaid covered services and integration of school and community services through activities to be conducted under the Casey Urban Mental Health Initiative Transitional Planning Grant awarded in August 1992.

Indicator IV/2a-C: The Commonwealth submits a Progress Report to the Casey Foundation and it is approved by the Foundation. The report outlines models for comprehensive service delivery, including single case management, integrated intake, linkage with Medicaid funded services and integration of school and community services. **Accomplished**.

Comparison: The Progress report modifies and expands upon the work done in SFY'93, and reflects ongoing consultation with parents, community providers and neighborhood residents.

Narrative: The parents involved in the Casey Project developed a paper outlining a continuum of care from the parent's perspectives. This paper has been presented at national forums. The program committee continues to meet, summer programs were funded for the summer of 1994, and RFPs are now being developed for a range of services. These new programs are expected to be put out to bid in SFY'95.

Objective IV/2b-C: Implement a pilot program to provide individualized services for multi-agency involved severely emotionally disturbed (SED) children in the Metro Boston Area to maintain them in their homes and/or communities.

Indicator IV/2b-C: DMH funds and establishes a program to provide individualized wrap-around services to multi-agency involved children who had come to the attention of the Metro Boston Interagency team. **Accomplished**.

Comparison: SFY'94 was the first year in which a specific contract was developed to provide funding for individualized services to this target population.

Narrative: In SFY'93, 15 children and families were served, 9 during the first months of operation, and 6 during the late spring. An analysis of the reasons for lower than expected utilization indicated that many of the direct service functions were already being provided through the agencies' home-based service teams, and that the referral process to this program was in itself a barrier to utilization. As a result of this analysis, the referral process was revamped in the spring, making the program directly accessible to state agencies, and the service parameters revised. The program is now functioning as a valuable resource, serving as a crisis assessment unit for children and families being referred to the interagency team.

Objective IV/2c-C: Maintain state funding for an interagency project in the city of Lynn, initiated with CASSP dollars, that focuses on interagency collaboration and use of wraparound funds. This project aims to enable children to remain at home and also to prevent out-of-district school placements.

Indicator IV/2c-C: The interagency project continues with funding provided by the Department of Mental Health, and with the full participation of the child-serving agencies in the Area. **Accomplished**.

Comparison: The level of trust among project team members rose considerably in SFY'94 as a result of continued working together and deliberate team-building activities. Ease in working together has enabled the team to accept more families than in SFY'93, as well as to continue to monitor the progress of families served earlier.

Narrative: Sixty-five families were served in SFY'94. Staff from all agencies participating in the project are now examining systemic policy barriers to effective service delivery. The Lynn project has provided a successful model for the Area so that another local interagency initiative is being established.

Objective IV/2d-C: Implement $2.2 million of community-based, non-residential programming across the state to serve children under 14 who might have been previously hospitalized at the Gaebler Children's Center.

Indicator IV/2d-C: Non-residential programming for children under 14 is established across the state. **Accomplished.**

Comparison: The amount of community based programming for latency age youth with severe emotional disturbances was expanded significantly in SFY'94. Prior to this new funding, only outpatient clinic-based counseling was generally available.

Narrative: Each of the seven DMH Areas received an allocation for community based programming. Funds were primarily used to establish intensive home-based intervention programs, respite services, after-school activity programs and individualized wrap around services.

Objective IV/2e-C: Use Block Grant funds to hire parent coordinators in each DMH Area to establish peer support groups for parents of children with emotional disturbances living at home to provide emotional support and information about access to services and entitlements, especially special education and SSI.

Indicator IV/2e-C: Parent support coordinators are hired in all seven DMH Areas. **Accomplished.**

Comparison: Whereas in SFY'93, parent support staff consisted of the director of the statewide parent organization and two Area-based coordinators, in SFY'94, parent support became available in each DMH Area. The number of support groups increased significantly.

Narrative: Eight new parent support coordinators were hired, and the two previously funded through CASSP maintained their positions. Some Areas decided to hire two coordinators, in order to provide better geographic coverage. In addition, AMI-CAN (Alliance for the Mentally Ill - Child/Adolescent Network) has a volunteer coordinator in the western part of the state. Twenty-four parent support groups are now operating. In addition, parent support coordinators have been successful in engaging parents in CCSS planning.

Objective IV/2f-C: Provide funded opportunities for case managers and state funded and volunteer parent coordinators to receive training in special education advocacy.

Indicator IV/2f-C: Training in special education advocacy is made available to case managers and parent coordinators. **Accomplished**.

Comparison: Although information about entitlements to special education was always included as part of case management training, SFY'94 was the first time there was a formal full day training in special education advocacy, reflecting a better understanding of the critical role education plays in the lives of children and the need for integration of mental health and education-related services.

Narrative: A full day training in special education advocacy was organized and specifically geared to the concerns of case managers and parent coordinators. Staff from the Federation for Children with Special Needs provided an overview of the special education federal and state laws, and rules and regulations governing the Individual Education Plan . The basics of IDEA and transition planning were presented. An attorney who specializes in education advocacy then answered specific questions and provided helpful hints to ensure appropriate plan development and service delivery.

Objective IV/2g-C: Participate on an interagency task force chaired by Division of Medical Assistance (DMA) to develop standards for school-based mental health services.

Indicator IV/2g-C: DMH staff take an active role on DMA task force. **Accomplished**.

Comparison: This is the first time DMA has developed specific standards related to school based services. The standards address key components of care and issues of coordination.

Narrative: The Task Force met in the winter and spring of SFY'93. Members included DMH Central Office staff, school-based mental health providers with DMH contracts, staff from major HMO's, representatives from the Boston School Department, and staff from DMA and MHMA, DMA's mental health and substance abuse vendor. Standards were developed that mandate formal school-agency coordination, spell out the responsibility of school-based providers to the families of children being served and provide guidelines for linkage with the children's HMO's. It is anticipated that these standards will facilitate access to services for children and families while ensuring coordination among all providers serving the family.

Objective IV/2h-C: In collaboration with the other state child-serving agencies, define thresholds and a protocol to prevent out-of-home placement.

Indicator IV/2h-C: EOHHS Children's Services Integration Committee, of which DMH is a member, defines thresholds for out-of-home placement and a protocol for agencies to follow. **Partially accomplished**.

Comparison: SFY'94 marked the first time the child-serving agencies collectively addressed the issue of thresholds for placement. For the first time, there is now movement toward an interagency placement protocol.

Narrative: The EOHHS Children's Services Integration Committee worked on defining mutually acceptable thresholds to out-of-home placement. Their preliminary work was presented in a report to the Secretary of EOHHS.. In June 1994, a joint DMH, DSS, DMA task force was established to design an interagency intake, assessment and triage model for families requesting voluntary out-of-home placements. This model, to be completed in SFY'95, will build on the work done related to thresholds for placement and will provide a placement prevention protocol.

Objective IV/2i-C: Develop and implement an interim policy with the Department of Social Services to triage youngsters for whom there has been a request for voluntary out-of-home placement with the goal of using pooled, flexible funds to maintain the child at home.

Indicator IV/2i-C: An interim policy is implemented. **Accomplished**.

Comparison: As a result of the SFY'94 interim policy, for the first time children with mental health problems whose parents were seeking placement for them through DSS were referred DMH and had access to the full range of DMH services geared to preventing placement, including case management, regardless of whether they would have normally met DMH's stringent eligibility criteria.

Narrative: In the first six months during which the interim policy was in effect, DMH received 194 referrals from DSS. It was originally estimated that 72 children would be referred annually. The policy proved effective, in that fewer than 10% needed placement. The successful experience in averting residential placement has contributed to the impetus for the establishment of a collaborative intake, assessment and triage process, referenced in Objective IV/2h-C.

REQUIREMENT #V: The State plan shall describe the financial resources and staffing necessary to implement the requirements of such plan; including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.

Since the Department's final state appropriation is evaluated by the legislature on a net state cost basis, revenue generation is a significant factor in supporting the Department's budget and its Public Managed Care initiative. Assuring the availability of human resources, including the availability of a qualified culturally diverse staff, enhancing the knowledge and skills of mental health care providers, and improving quality management services have been important to continued system development.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Funds Available for Community Programs

GOAL V/1: DEVELOP AND IMPLEMENT FISCAL POLICIES THAT SUPPORT PUBLIC MANAGED CARE INITIATIVE GOALS.

Objective V/1a: Generate revenues to support program initiatives.

Category	Actual '93	Projected '94	Actual '94
State hospitals (A)	$6.39m	$6.36m	$8.00m
Rehab Option (A)	$18.76m	$17.32m	$19.08m
CMHCs (A)	$11.44m	$11.80m	$12.97m
IRTPs (C)	$.51m	$1.00m	$6.39m
Adol. Inpat. Units (C)	$5.50m	$4.88m	$6.12m
Rehab Option (C)	2.13m	$1.00m	$2.06m
Case Managemt (S)	$10.73m	$12.00m	$10.62m
Replacemt Units (S)	N/A	$9.82m	$4.52m
Total	**$55.46m**	**$64.18m**	**$69.76m**

Narrative: DMH did not receive revenue for replacement units in SFY'93. In that first year, claims were paid by DMA and DMA was credited with the revenue (FFP) that accrued to the General Fund. SFY'94 actual revenues exceeded projections by more than $5.5 million. Although revenue from replacement units was significantly under projections, much of the unrealized revenue will be captured during subsequent fiscal periods. The Department focuses on managing various sources of revenue to ensure that overall targets are met.

Meeting its obligations to the General Fund of the Commonwealth ultimately lends support to the Department's total appropriation level.

Availability of Human Resources

GOAL V/2: DEVELOP AND IMPLEMENT POLICIES RELATED TO EMPLOYMENT, STAFF DEVELOPMENT AND STAFF DIVERSITY THAT SUPPORT PUBLIC MANAGED CARE INITIATIVE GOALS, ENSURE ACCOUNTABILITY THROUGHOUT THE DMH SERVICE SYSTEM AND RESPECT AND PROTECT THE RIGHTS OF CONSUMERS.

SHARED OBJECTIVES

Objective V/2a-S: Implement a merit-based pay program for all DMH managers which provides for annual performance reviews and communication and measurement to progress toward agency goals.

Indicator V/2a-S: Initiate a performance appraisal process for DMH managers. **Accomplished**.

Comparison: Prior to SFY'94, performance reviews for managers were inconsistent and wages stagnated since 1986. The merit-based pay program, based on SFY'93 performance, was implemented in SFY'94 The performance reviews, as required by legislation, were completed on all 326 DMH managers in December 1993.

Narrative: The performance appraisal process for managers and subsequent merit increases, based on SFY'94 performance, is slated for implementation during SFY'95. However, DMH has not received notification of an appropriated to fund merit pay increases for the managers' SFY'94 reviews.

Objective V/2b -S: Implement a performance review program for all Department of Mental Health Bargaining Unit employees, to take effect in SFY'95. Commence negotiations immediately with affected bargaining units to ensure July 1994 implementation of goal setting activities. Such negotiations would include linkage with merit-based salary adjustments but would not require compensation link to commence program. (This is a two year program.)

Indicator V/2b -S: The Commonwealth and the Massachusetts Nurses Association (MNA - one of the DMH employee bargaining units) sign a settlement

agreement, including a "pay for performance" evaluation system. Negotiations to conclude collective bargaining agreements, including provisions for a similar performance evaluation system, commence with the other DMH employee bargaining units - NAGE and AFSCME-SEIU. **Accomplished**.

Comparison: In 1987 there was a one-year bonus program based on a performance rating. Between 1987 and SFY'94, there were no provisions in the collective bargaining contracts for "pay for performance."

Narrative: The MNA contract was settled in SFY'94 and provided for a salary increase, effective October 1, 1994, based on SFY'94 performance. Negotiations with the other DMH employee unions are ongoing but have not progressed to the settlement stage. DMH strongly supports the "pay for performance" concept which is designed to provide linkage between employee performance and the DMH mission, goals and budget performance indicators.

Objective V/2c-S: Secure appropriate positions and classification levels for field and Central Office managerial positions. Said positions should reflect the organizational structure adopted by Department of Mental Health Executive Staff consistent with the Public Managed Care Initiative.

Indicator V/2c-S: Management Position Description Questionnaires are completed by position incumbents and reviewed by the evaluation team, comprised of Department of Personnel Administration, DMH and Hay Associates personnel. **Accomplished**.

Comparison: A classification effort of this magnitude has not been conducted since 1987.

Narrative: Over the last few years, DMH significantly revised its management and organizational structure to reinforce accountability, streamline administrative processes and ensure resources are appropriately dedicated to service delivery. This restructuring has been guided by the CCSS planning process, complemented by the agency's movement to a "delegated" approach to service planning and local decision making. Given the magnitude and speed with which changes have occurred, it was not always possible to engage in drawn-out classification analyses for the new structures. The allocation of human resource staff to such activities as staff outplacement and personnel downsizing did not allow for thoughtful documentation of new positions and management functions. In addition, the uniqueness of each DMH Area did not allow for the application of uniform statewide classification levels and required that any valid analysis be conducted in an incumbent-specific manner.

Considering the scope of the task, DMH opted to enlist the assistance of Hay Associates, a national firm experienced in undertaking similar tasks in large,

complex organizations. The incumbent-specific job documentation and classification study was completed for each Central Office and field position judged by Area Directors and Central Office senior staff to be managerial in content. A total of 393 positions were reviewed. Implementation of the study recommendations will occur in SFY'95.

Objective V/2d-S: Establish a program for the recruitment, hiring, training and retaining of qualified or qualifiable persons to fill managerial and professional positions to assure the development of staff to meet the needs of consumers with diverse cultural and linguistic needs. Hiring of qualifiable personnel contemplates hiring individuals into a three-year intern program, in principal occupations, culminating in retention at the journeyman grade level of a particular career field.

Indicator V/2d-S: The work force analysis report for the current calendar year is reviewed to identify any employees in positions designated as trainee or intern categories. **Accomplished**.

Comparison/Narrative: In SFY'93, the concept and a plan were developed to establish intern training positions in the Department. In SFY'94, however, no action was taken to implement this proposal because it was not deemed feasible to increase funding for additional managers during reductions in force due to facilities closing and/or downsizing. Therefore, full implementation was not achieved.

Objective V/2e-S: Complete computerization of complaint administration, documents and pertinent files for contracting and affirmative action programs.

Indicator V/2e-S: Contract and complaint administration files in the EEO/AA Office are computerized. **Partially accomplished.**

Comparison: The SFY'93 objectives extended to conceptualization, planning and initiating entry of the contract and complaint administration functions into the computer system. In SFY'94, the contract administration files, with supporting documentation, were entered into the computer system. Concurrently, segments of the complaint administration operation were computerized.

Narrative: Whereas the contract data were computerized to permit ready access to contract procedures, the complaint administration processes presented barriers to total computerization. Problems in implementation were

attributable to the complexity and non-uniform character of the materials and the fact that an experienced computer staff person was not available to assist.

The computerization of the contract administration was accomplished. Complaint administration processes are approximately 40% completed.

Objective V/2f-S: Sustain the 1993 implementation effort to review DMH regulations, operational policies and practices, and review all Requests for Proposals, to ensure compliance with the Americans with Disabilities Act of 1990. Expand the effort to increase involvement and participation in all DMH Areas. Provide statewide ADA training to vendor contractors.

Implementation of Objective V/2f-S is discussed in Objective III/3e-S (page 54).

Objective V/2g-S: Assist the DMH Areas in developing hiring and other strategies to increase consumers' access to any program, regardless of their limited proficiency in English, as required by the Federal Civil Rights Act and the ADA.

Indicator V/2g-S: ADA transition plans from all DMH Areas are reviewed to ensure compliance with ADA requirements for access to programs and facilities. **Accomplished**.

Comparison: In SFY'93, DMH provided training in ADA requirements to all DMH Areas and some providers. SFY'94 operations included development of Area transition plans to implement the ADA requirements for accessibility to programs and facilities.

Narrative: Although the implementation phase was fully accomplished throughout the Department, the monitoring phase is still in the process of development.

Objective V/2h-S: Continue monitoring efforts to ensure that vendor contractors and DMH programs maintain staffing that provides care, treatment and services to minorities, the physically impaired and consumers requiring linguistic services. Endeavor to increase participation of vendor contractors in the monitoring function.

Indicator V/2h-S: The SFY'93 and SFY'94 work force analyses are compared regarding staffing patterns. **Accomplished**.

Comparison: The SFY'93 year end work force analysis disclosed that there were 11.9% minorities in the Officials/Administrators category and 10.2% minorities in the Professional Occupations category. Subsequent data from the SFY'94 year end report reflected 10.9% in the Officials/Administrators category and 10.7% in the Professional occupations. Therefore, maintenance of effort was sustained.

Narrative: Although there was an increase in the number of minority professionals, the effort to substantially increase minority representation is inhibited by the continuing reduction in the work force of the Department.

Objective V/2i-S: Provide technical assistance through the DMH EEO/AA Office to appointed committees concerned with assisting vendor contractors to ensure accessibility to programs and facilities for consumers with multicultural, linguistic and other special needs.

Indicator V/2i-S: The DMH EEO/AA Office provides technical assistance to support the Multi-Cultural Advisory Committee, the Area ADA committees and other committees established to address the special needs of consumers. **Partially accomplished**.

Comparison: The SFY'93 objective was directed toward planning to determine the availability of bilingual and bicultural clinical staff. This planning also sought to link this specially skilled staff to the generation and interpretation of treatment data, participation and formulation of treatment plans and inclusion of family members. In SFY'94, technical assistance was provided to committees established to implement ADA functions in each Area, to the DMH Multi-Cultural Advisory Committee which is under Central Office aegis, and to a Cultural Competence Committee that supports training for staff and vendors in cultural competence.

Narrative: Although the committees have been highly effective and have aided in integrating these special functions into daily operations, additional training of staff is needed. Lack of funding has delayed full implementation.

Training

GOAL V/3: DEVELOP AND ENHANCE THE KNOWLEDGE BASE AND SKILL LEVEL OF HEALTH CARE PROFESSIONALS DELIVERING SERVICES TO DMH PRIORITY CONSUMERS.

SHARED OBJECTIVES

Objective V/3a-S: Continue Train-the-Trainer days and the development of practice guidelines in the areas of: role of the family, psychosocial rehabilitation, multicultural issues and human and legal rights, including alternatives to restraint and seclusion.

Indicator V/3a-S: Practice guidelines are developed for role of the family, human and legal rights and alternatives to restraint and seclusion. **Partially accomplished.** (See Narrative below)

Comparison: In SFY'93 there were no standardized guidelines for providers and state agencies on the role of the family and alternatives to restraint and seclusion. Aspects of human rights were updated in SFY'94, and two human rights conferences were held during SFY'94.

Narrative: The multicultural and psychosocial rehabilitation workgroups requested extensions of time to complete their work. It will be completed in SFY'95. Therefore, three of five topics covered under this objective were completely implemented and two were partially implemented.

Objective V/3b-S: Complete Part 2 of video production addressing HIV Prevention and Risk Reduction, in a format suitable for viewing by consumers.

Indicator V/3b-S: Part 2 of video is completed and distributed. **Accomplished**.

Comparison: In SFY'93, only Part 1 of the video was completed; Part 2 completes the series.

ADULT ONLY OBJECTIVE

Objective V/3c-A: With Department of Higher Education, complete development of practice guidelines and curriculum for a certificate program for DMH and provider residential house staff.

Indicator V/3c-A: Practice guidelines and a curriculum for a certificate program for residential house staff are completed. **Partially accomplished**.

Comparison: In SFY'93, no practice guidelines or curriculum existed.

Narrative: The committee working on this curriculum needed longer than expected to conceptualize and complete its work and requested an extension of

its deadline. The curriculum was sent out during SFY'94 for a professional re-write, and the committee found the re-write unacceptable and in need of further revisions. Revised target dateis January-March, SFY'95.

Objective V/3d-A: Continue initiative to teach the DMH core curriculum to every state and vendor employee. (five year project)

Indicators V/3d-A:

- The Central Office Training Program provides guidelines for role of the family, alternatives to restraint and seclusion and human rights. **Accomplished**.
- A training director is appointed for each DMH Area to repeat trainings in the core curriculum yearly. **Accomplished**.
- DMH Central Office provides technical assistance to these Area training personnel and updates all training materials. **Accomplished**.

Comparison: In SFY'93, neither the training nor technical assistance were available.

Narrative: Although the core curriculum referenced above was developed primarily to address adult services, some of the training topics are applicable to both the adult and child/adolescent systems (e.g. human rights). In addition, the training directors are responsible for training in both systems.

CHILD-ONLY OBJECTIVE

Objective V/3e-C: Complete child/adolescent core curriculum. Follow with statewide assessment to identify training needs and form clinical practice groups, as needed, to implement.

Indicator V/3e-C: Core curriculum is written. Meetings are held with field staff to identify training needs. **Partially accomplished.**

Comparison: This is the first time a core curriculum has been developed geared to both DMH staff and contracted program providers, and specifically focused on child-adolescent issues. Prior to this, a training manual for DMH case managers represented the only available curriculum.

Narrative: There was a delay in getting the core curriculum on the Area Directors' agenda, which delayed implementation of this initiative. Thus, clinical practice groups were not established in SFY'94, but will be established in SFY'95 to develop standards and curriculum materials.

Objective V/3f-C: Continue to sponsor annual training for providers of inpatient and IRTP services.

Indicator V/3f-C: One day training for inpatient and IRTP providers is held. **Accomplished**.

Comparison: Although there have been annual trainings for the past several years for these two groups, SFY'94 was the first year that a conjoint training was held for IRTP and inpatient providers. For the first time, the training included a panel of adolescents and parents from the programs.

Narrative: The training was held October 22, 1993. Highlights included a speaker on dissociative phenomena and the panel of parents and adolescents.

Objective V/3g-C: Sponsor training that brings together child and adolescent service providers across the continuum of care to address issues of system integration, family involvement and resource utilization.

Indicator V/3g-C: A training on systems integration for child service providers is held in one Area. **Accomplished**.

Comparison: This was the first Area-wide formal training for all child-serving providers in an Area on systems integration.

Narrative: The training was held June 28, 29, and 30, 1994 for vendors in the Cape Cod, Brockton and Plymouth CCSS areas. Attendees included Area Directors, CCSS site directors, regional and area office staff from DSS, DMH, the local education authorities, the Department of Education, juvenile court staff, the probation departments and MHMA. The agenda included a discussion of how Stark County, Ohio developed the infrastructure for a seamless system of care for children with serious emotional disturbances, and an analysis of the barriers and problems involved in serving this population. A follow-up conference for December 1994 has been planned.

Objective V/3h-C: Complete development of a video library of orientation tapes to all DMH child and adolescent inpatient and IRTPs for use by staff and families to better understand program options.

Indicator V/3h-C: Individual video tapes of inpatient and IRTP units are available. **Almost fully accomplished.**

Comparison: This activity began in SFY'93. It was one tape short of completion in SFY'94.

Narrative: Parental permission to include one child in one of the tapes was withdrawn after having been given initially. The difficulty of editing out all

material related to that child created a delay in completing one tape. The tapes are being actively used to orient acute inpatient providers about IRTPs and units providing extended hospitalization, and are used by case managers to inform children and families about programs.

GOAL V/4: TARGET TECHNICAL ASSISTANCE AND CONSULTATION AT IMPROVING QUALITY MANAGEMENT PRACTICES.

SHARED OBJECTIVES

Objective V/4a-S: Conduct "just in time" training on quality improvement approaches and methods for all quality improvement teams working on improvement projects identified by the DMH Quality Council.

Indicator V/4a-S: Training in the use of a structured problem solving process and the tools of continuous improvement is provided by experienced facilitators to seven quality improvement teams sanctioned by the DMH Quality Council. **Accomplished**.

Comparison: During SFY'93, quality management training activities focused on Total Quality Management training for the leaders of the organizations and theories and principles of performance assessment and improvement for the Department's quality management professionals.

In SFY'94, DMH's quality management training efforts expanded to include line staff, family members and consumers who worked on specific problem identification and problem solving activities. Over 100 individuals were members of DMH Quality Council improvement teams and received the "just in time" training.

Narrative: Nine teams representing adult and child/adolescent programs and a cross section of the Commonwealth began working on quality improvement projects. Over 100 individuals participated as team members.

Objective V/4b-S: Establish a training program to provide detailed education in approaches and methods of quality improvement for team leaders and facilitators.

Indicator V/4b-S: A cadre of DMH staff trained in the values, tools and techniques of Total Quality Management act as facilitators for the DMH Quality Council sanctioned quality improvement teams. **Accomplished**.

Comparison: During SFY'94, three DMH staff received extensive facilitator training. These individuals provided the "just in time" training to the quality improvement teams identified in Objective V/4a-S. In SFY'93, no trained facilitators were working in the Department's Central Office.

Emergency Services Training

GOAL V/5: DEVELOP AND IMPLEMENT TRAINING FOR PROVIDERS OF GENERIC EMERGENCY SERVICES AND EMERGENCY HEALTH SERVICES.

SHARED OBJECTIVES

Objective V/5a-S: Complete evaluation of emergency training provided for shelter staff and agency heads by caregivers and agency administrators to determine effectiveness.

Indicator V/5a-S: The Executive Office of Health and Human Services (EOHHS) conducts monthly interagency meetings of health, welfare, corrections, etc., staff to coordinate and standardize services and train shelter staff. **Accomplished.**

Comparison: Monthly interagency meetings continued as in SFY'93. but a decision was made not to hold an annual teaching conference in SFY'94.

Narrative: Although annual teaching conferences were held in previous years, EOHHS elected not to have the annual training in SFY'94 because of EOHHS internal agency changes. The agencies submitted several topics for future conferences and EOHHS will notify participating agencies of revised timelines.

Objective V/5b-S: Provide follow-up training to crisis counselors trained originally under the FEMA/NIMH Crisis Counseling grant and recruit and train new crisis counselors.

Indicator V/5b-S: Training for crisis counselors occurs at the Area level, including statewide participation in drills and selected participation in nuclear preparedness crisis counseling response. **Accomplished.**

Comparison: In SFY'93, training was held statewide and only supervisory staff were able to attend. In SFY'94, training was offered to each DMH Area and most Areas requested and received training. Also in SFY'94, front line crisis counselors were able to attend the Area trainings.

Narrative: Consistent with DMH's commitment to CCSS development and enhancing local response capacity, all Areas were offered crisis counseling training. A statewide notification drill was activated during the summer for DMH along with other Emergency Management agencies as part of the statewide Emergency Management preparation for summer storms. All Areas participated and learned from this drill (self-reported). Two Areas containing nuclear power plants also participated in selected training and drills for crisis counseling during

SFY'94. One Area that will participate during SFY'95 in the federally graded drill for the New Hampshire Seabrook Nuclear Power Plant began actively preparing for this.

REQUIREMENT #VI: The State plan shall provide for activities to reduce the rate of hospitalization of individuals with a serious mental illness or emotional disturbance.

During the past few years, DMH has achieved significant reductions in the rate of hospitalization. Activities during the past year focused on "rightsizing" the system, including creating additional community alternatives to hospitalization, and operationalizing a utilization management system to assure that all consumers receive high quality treatment in the most clinically appropriate setting.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Consumers in Hospitals

GOAL VI/1: ASSURE THE AVAILABILITY OF AN APPROPRIATE NUMBER OF CRISIS PLACEMENT AND RESPITE CARE BEDS TO SERVE CHILDREN IN CRISIS OUTSIDE OF INPATIENT SETTINGS.

CHILD ONLY OBJECTIVE

Objective VI/1a-C: Establish additional crisis placement/respite beds in accordance with Area needs as identified in CCSS plans.

Indicator VI/1a-C: Additional crisis placement/respite beds are established. **Accomplished**.

Comparison: In SFY'93, there were 16,481 crisis placement/respite bed days; in SFY'94, an additional 3,194 crisis placement/respite bed days were created, in three Areas.

Narrative: All new beds added to the system have the capability to serve latency age children. In addition, one existing respite program lowered its age limit to serve latency age children as well as adolescents.

Programmatic Initiatives to Reduce Hospitalization

GOAL VI/2: PUT A STATEWIDE UTILIZATION MANAGEMENT (UM) PROGRAM INTO OPERATION TO SYSTEMATICALLY MONITOR AND IMPROVE THE PROVISION OF HIGH QUALITY, EFFECTIVE AND INTEGRATED TREATMENT SERVICES TO CONSUMERS IN THE MOST CLINICALLY APPROPRIATE AND LEAST RESTRICTIVE SETTING, WHILE MAXIMIZING THE EFFICIENT USE OF THE DEPARTMENT'S RESOURCES AND PROTECTING CONSUMERS' LEGAL RIGHTS.

Objective VI/2a-S: Complete and review ratification of UM standards

Indicator VI/2a-S: The DMH Policy and Planning Committee reviews and approves the UM standards. **Accomplished**.

Comparison: In SFY'93, there were no UM standards.

Narrative: The UM standards were initially reviewed and approved by the Policy and Planning Committee in December 1993. After modifications by the Executive Staff and Commissioner, the UM standards were approved and promulgated to the field in March 1994.

Objective VI/2b-S: Work with the Areas to put UM standards into operation beginning in January 1994; complete by December 1994.

Indicators VI/2b-S:

- An implementation plan for UM standards is developed. **Accomplished**.
- Areas begin to implement the standards; training is provided. **Accomplished**.
- A baseline in relation to each standard is established and Areas are assisted in developing work plans to accomplish full implementation in SFY'95. **Accomplished**.

Comparison: In SFY'93, there were no UM standards.

Narrative: An implementation plan for the UM standards was developed as a collaborative effort of the Divisions of Clinical and Professional Services and Program Operations within DMH. Training was provided to all of the seven Areas regarding the standards. Work with the Areas was begun to assess baseline performance in relation to each of the standards and to assist them in developing a work plan to fully implement the standards beginning in calendar year 1995.

Objective VI/2c-S: Complete clinical criteria for all levels of care.

Indicator VI/2c-S: Clinical criteria for inpatient, emergency services, day treatment and partial hospitalization services are completed. **Accomplished**.

Comparison: In SFY'93, no statewide DMH clinical criteria existed.

Narrative: Clinical criteria for all levels of inpatient care have been completed. Criteria for emergency services (crisis stabilization and respite care services) have also been completed. Partial hospitalization and day treatment clinical criteria for adults were approved by the Policy and Planning Committee and are currently under review by the Commissioner and Executive Staff.

Clinical standards for residential programs under the Department's new single residential code program initiative were developed. Work is currently underway to develop associated clinical criteria which will be used to decide which consumers will be admitted and continue to receive residential services. The next step is to link existing UM standards regarding residential services to these clinical criteria.

Objective VI/2d-S: Monitor implementation of clinical criteria and protocols developed with Division of Medical Assistance (DMA) and Mental Health Management of America (MHMA), DMA's mental health and substance abuse program vendor, to evaluate and continually improve the quality of care provided to shared consumers. This will include a review of patient records in all DMH Areas.

Indicator VI/2d-S: Reports based on an analysis of a combined DMH/DMA data base are produced. **Accomplished**.

Comparison: In SFY'93, no database was available, therefore no analysis was conducted.

Narrative: DMH has worked collaboratively with DMA and MHMA to produce reports analyzing inpatient utilization patterns for shared consumers. In addition to this analysis, these reports have compared similar DMH and MHMA programs. A statewide meeting was held to review the results and DMH Area staff were apprised of the outcome.

Objective VI/2e-S: Continue to educate staff, providers and consumers about the Department's UM activities and the principles of managed care.

Indicators VI/2e-S:

- Statewide training is provided to DMH staff, providers and consumers regarding the Department's public managed care initiative; this training includes a component on utilization management. **Accomplished**.
- Separate training is planned for all Areas specifically on the new UM standards and implementation of UM activities. **Accomplished**.

Comparison: In SFY'93, no formal training on public managed care or the UM standards was carried out.

Narrative: Training was provided to all Areas on public managed care in SFY'94 and to half of the Areas regarding the new UM standards. The remainder of these "train the trainer" sessions will be completed in the first quarter of SFY'95. The purpose of the training is to prepare both DMH staff and vendors for full implementation of the UM standards in January 1995, including data collection, reporting and analysis of service system utilization.

Objective VI/2f-S: Work with health maintenance organizations (HMOs), mental health care insurers and other involved parties to promote a seamless and integrated mental health care system for consumers in the state.

Indicator VI/2f-S: DMH meets with HMOs to discuss ways of promoting a seamless and integrated mental health care system for consumers in the state. **Accomplished**.

Comparison: In SFY'93, no dialogue existed between DMH and HMOs.

Narrative: In SFY'94, the Department had discussions with Blue Cross/Blue Shield of Massachusetts and with HMOs, including Harvard Community Health Plan, Tufts, Pilgrim and Fallon regarding universal adoption of the Department's adult and child/adolescent clinical criteria and protocols. These discussions are on-going.

Objective VI/2g-S: Standardize data collection and analysis methods in collaboration with the DMH Applied Information Technology division (AIT).

Indicator VI/2g-S: Two standardized inpatient UM reports are issued. **Accomplished**.

Comparison: In SFY'93, there were no standardized inpatient UM reports.

Narrative: During SFY'94, a user-friendly inpatient utilization management report was developed. This report, which the Department expects to issue

quarterly once all technical problems are resolved, includes graphic representation of similar programs' performance as well as comparative performance of the seven DMH Areas. The report is used at the program and Area level to monitor and continually improve performance. For example, one of the state hospitals, noting that its recidivism rate was amongst the highest in the state, organized a quality improvement committee to analyze the problem and recommend areas for improvement.

Objective VI/2h-S: Merge databases from DMA/MHMA and DMH regarding hospital utilization. Analyze data according to specific indicators such as admission rates, bed days, re-admission rates and transfer between the two service systems to ensure consumers have appropriate access to inpatient services, no more or less than needed. Examine flow of patients between service systems to ensure a seamless and integrated system of care. Look at number of facilities used to treat individual consumers to ensure that persons in need of multiple admissions continue to receive their care at the same facility.

Indicator VI/2h-S: All planned analyses of merged inpatient data (DMH and DMA/MHMA) are completed. **Accomplished**.

Comparison: In SFY'93, DMH and MHMA shared data, created the database structures and began the analyses; in SFY'94, they continued to share data, and completed the planned analyses of specific indicators.

Narrative: Although the analyses were completed, the data have not been approved for release by either the Secretary of EOHHS or the two commissioners.

REQUIREMENT #VII: The State plan shall require the provision of case management services to each individual with a serious mental illness or emotional disturbance in the State who receives substantial amounts of public funds or services.

DMH has been actively engaged in the process of reconfiguring its case management structures to serve the needs of its Public Managed Care system, and to facilitate development of a unified case management system for children and adolescents served by state agencies.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Case Management Model

GOAL VII/1: RECONFIGURE DMH CASE MANAGEMENT INTO A SERVICE DELIVERY SYSTEM THAT IS EQUIPPED TO MEET THE CHALLENGES AND EXPECTATIONS OF A PUBLIC MANAGED CARE INITIATIVE.

SHARED OBJECTIVE

Objective VII/1a-S: Complete a formal, written report to the Commissioner that describes a new case management plan and outlines implementation steps to be taken.

Indicator VII/1a-S: A plan is submitted. **Accomplished**.

Comparison: The case management plan needed to be updated to incorporate goals related to community expansion and implementation of public managed care initiatives.

Narrative: Case management has been framed in the context of the broader Care Management structure of the Department. This has the advantage of articulating the multiple continuity of care mechanisms employed by the Department and the specific roles and responsibilities of case managers within this larger context. The hoped for result is a reduction in duplication of functions and increase in direct consumer contact.

GOAL VII/2: AS PART OF AN EOHHS SPONSORED INTERAGENCY ACTIVITY, CONTINUE TO PARTICIPATE IN THE DEVELOPMENT OF A UNIFIED CASE MANAGEMENT SYSTEM FOR CHILDREN AND ADOLESCENTS SERVED BY STATE AGENCIES.

Objective VII/2a-C: Develop a proposal for presentation to the Secretary of EOHHS to address the issue of a unified case management system.

Indicator VII/2a-C: A proposal is presented to the Secretary of EOHHS. **Accomplished**.

Comparison: Although the need for unified case management had previously been discussed, no specific proposal had ever been put forward.

Narrative: As part of work for a grant application developed by the Western Mass. Area, for submission by the Secretary of EOHHS to the Center for Mental Health Services, two proposals for unified case management were developed. The one endorsed by the Secretary served as a base for the application. In addition, a joint committee of DMH, DMA and the Department of Social Services is further addressing this issue in the course of developing a collaborative intake, assessment and triage process.

Size of Population Receiving Case Management Services

GOAL VII/3: THE LONG-TERM GOAL OF THE CASE MANAGEMENT SYSTEM IS TO PROVIDE A CONTINUUM OF SERVICES TO ALL IDENTIFIED CONSUMERS OF DMH BASED ON THE LEVEL OF CARE REQUIRED.

SHARED OBJECTIVE

Objective VII/3a-S: Provide case management services to 7,200 adult and 750 child and adolescent DMH priority consumers.

Indicator VII/3a-S: Case management services are provided to at least 7,200 adult and 750 child and adolescent consumers at any point-in-time during the fiscal year. **Accomplished**.

Comparison: On June 30, 1993, 7,597 adults and 826 children were receiving DMH case management services. During SFY'93, a total of 9,193 adults and 1,473 children received DMH case management services. On June 30, 1994, 7,797 adults and 981 children were receiving DMH case management services. During SFY'94, a total of 9,836 adults and 1,516 children received DMH case management services.

Narrative: Although the Department has been able to consistently increase the availability of case management services for adults and children over the last two fiscal years, it has decided not to set new statewide targets until the new case management plan (see above) has been approved. It is anticipated this will occur before the end of SFY'95 and will be reflected in the 1996 State Plan.

REQUIREMENT #VIII: The State plan shall provide for the establishment and implementation of a program of outreach to, and services for, individuals with a serious mental illness or emotional disturbance who are homeless.

Massachusetts operates a comprehensive program of outreach to individuals with mental illness who are homeless. The PATH grant continues to provide clinical social workers across the state who provide direct care, housing advocacy and assistance as well as referrals for job training, literacy education, mental health services, substance abuse treatment and programs that provide benefits and entitlements.

Through a NIMH and McKinney Demonstration project, 118 former shelter residents were placed and continue to be followed in two housing models, independent apartments and Evolving Consumer Households. Preliminary findings indicated that 70% of those placed were still in their originally assigned housing and only 16% had returned to shelters or were living on the street. A final report is being issued and disseminated.

DMH has been managing transitional residences (formerly "shelters") for homeless mentally ill (HMI) individuals in the Metro-Boston Area. These programs receive referrals from non-DMH shelters and have been oriented towards stabilization and placement. Each program is affiliated with a community mental health center and has clinically trained staff. In SFY'94, DMH worked to improve coordination between these transitional residences and the mainstream community mental health centers.

DMH 's Homeless Outreach Team in the Metro Boston Area continued to identify people in need of services, and connected them with entitlements, case management and other services. DMH also continued to provide psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication compliance.

In addition, DMH sponsored the following programs for preventing and dealing with homelessness:

Services for Consumers in Public and Assisted Housing

The Commissioner instructed each Area Office to establish formal services linkage and understandings with the housing community, and to pursue Affiliation Agreements with local housing authorities and management offices of assisted housing developments financed by the Massachusetts Housing Finance Agency (MHFA).

An Affiliation Agreement identifies the service role of a DMH Area Office and reiterates DMH's commitment to respond to calls for assistance from the housing agency. It also covers referral procedures when the person needing help turns out to be someone whose problematic behavior is not caused by mental illness.

DMH Discharge Policy and Protocol

DMH has a discharge policy aimed at preventing homelessness. Specifically, the policy states that the Department will in no instance discharge a consumer from a facility with directions to seek housing or shelter in an emergency shelter, and that every effort should be made to help the consumer find adequate, permanent housing. Should a DMH discharge result in a shelter residence or homelessness, it can almost always be ascribed to circumstances beyond DMH's legal control or services-related influence.

DMH instituted an enhanced discharge protocol for its Metro-Boston Area Office, the area with the highest number of homeless persons in the state. Metro Boston operates a Homeless Services Unit which, among many other functions, monitors the discharge process, and strives to identify supportive housing options for consumers.

All individuals being discharged from state-operated facilities and acute care replacement units are involved in an individual service planning process that includes a hospital treatment team and case manager who determine the residential and support needs of each individual as well as their eligibility for entitlements.

DMH Comprehensive Planning/Consumer Participation

DMH allocates program resources, including those dealing with homelessness prevention, through Area Offices which in turn deliver services to consumers directly or by executing services contracts with private vendors. Planning for service delivery and resource allocation is accomplished through an annual participatory Comprehensive Community Support System (CCSS) process at the community level under the aegis of each Area Office. Each Area is required to file its formal, comprehensive plan, including an Area Housing Plan that includes homelessness prevention and mitigation strategies, with the Commissioner's office.

Each of DMH's seven Area Offices administers several sub-areas (CCSS). Plans are developed for each CCSS and then rolled up into a plan for the entire Area. The CCSS planning process involves DMH staff, consumers, family members, vendors, local human service agencies and other interested parties. Preventing and dealing with homelessness among persons with mental illness is expected to be addressed in each local CCSS plan.

Accessing Permanent and Transitional Housing Resources

DMH has aggressively pursued subsidized transitional as well as permanent housing opportunities for consumers who are at risk of becoming homeless after leaving a hospital, intensive treatment or residential program. DMH attempts to help consumers find affordable housing, although consumer need far exceeds the amount of affordable, subsidized housing DMH is able to access. DMH is also committed to providing appropriate levels of support to consumers residing in transitional housing as well as to those fortunate enough to obtain permanent housing.

In SFY'94, DMH was instrumental in helping its housing partners secure over $12 million in housing assistance for DMH consumers. These efforts are continuing in SFY'95.

DMH Chapter 52 "Capital Pooling" Housing Development Program

Policies and regulations were issued in SFY'94 for a DMH-EOCD (Executive Office of Communities and Development) $30m housing development financing program, part of a $50m DMH/DMR Capital Pooling program. DMH plans to use it, in part, to provide permanent housing for consumers with no residential alternatives, thereby preventing homelessness. Of the authorized amount, $10 million is explicitly set aside for creating housing for psychiatrically disabled homeless persons. DMH hopes to develop a variety of housing options, including integrated, independent living units through the program.

The new program will provide equity loans to help finance community housing being developed by non-profit organizations for persons with mental illness. Eligible groups will be able to receive equity loans covering up to 30% of the total development cost of approved housing construction or rehabilitation projects for DMH consumers. In addition, DMH will be able to enter into long-term leases with housing providers under the new program. The program is expected to be coordinated with federal and other local and state affordable housing financing programs.

Massachusetts Technical Research Project on Homelessness and Mental Illness

In formulating policies and programs for preventing as well as dealing with homelessness among the psychiatrically disabled, DMH has drawn from a major report issued in October 1992 by the Human Services Research Institute (HSRI). The study was commissioned as a technical assistance project by DMH and the Massachusetts Division of Capital Planning and Operations. The report identified the reasons for homelessness and discussed service models as well as available resources for helping this population. It provided information which has been very useful to DMH in devising both treatment and prevention-oriented strategies.

HSRI estimated there are up to 8,957 homeless adults in Massachusetts, 5,921 of whom are concentrated within the Metro-Boston Area. Upwards of 2,000 have a severe and persistent major mental illness (1,200 in the Metro-Boston Area and 800 elsewhere in the state).

DMH and HSRI recognize that the estimates of homeless persons with severe mental illness in Massachusetts do not include all homeless persons for whom the Department should strive to deliver services. Homeless persons with personality disorders and other less severe problems constitute a significant population which is difficult to quantify.

In identifying subpopulations, the HSRI study indicated that up to 1,151 of the total 2,000 homeless mentally ill adults in Massachusetts have co-occurring serious mental illness and substance abuse disorders.

The study's findings and recommendations were incorporated into the Statewide Action Plan set forth in April 1993 by the Commonwealth's Interagency Task Force on the Homeless Mentally Ill. The Task Force and Action Plan are discussed below.

Interagency Task Force on the Homeless Mentally Ill

As recommended by the Governor's Commission on Facilities Consolidation, the Commonwealth's Interagency Task Force on the Homeless Mentally Ill continued its work through early SFY'94. First convened in 1992 and co-chaired by the Secretaries EOHHS and EOCD, the task force was comprised of DMH, DPH, DPW, other state agencies and service providers working with homelessness.

One of the Task Force's goals was to ensure adequate alternatives for DMH consumers affected by the closing or downsizing of a facility. The Task Force proved to be a valuable mechanism for coordinating communication among participants on issues, policies, strategies, housing and service delivery.

As a subcommittee of the Task Force, a DMH Workgroup on People Who are Mentally Ill and Homeless has been meeting since 1991. It includes advocates, clinicians, management staff from other state agencies, consumers, family members, providers, direct care workers and academics and has addressed both services and prevention approaches.

The Work Group contributed to developing the statewide Action Plan for People Who are Mentally Ill and Homeless, issued in April 1993 through the Interagency Task Force. The Plan set forth an extensive set of treatment and prevention-oriented activities on which state agencies could collaborate to meet the housing and services needs of the homeless and mentally ill.

DMH Special Initiative To Serve The Homeless Mentally Ill

Several of the Action Plan's recommendations served as the basis for the DMH Special Initiative on the Homeless Mentally Ill, submitted to the legislature for consideration and enactment in the SFY'94 budget.

The legislature appropriated $3.3 m to be used by DMH for homeless services for part of SFY'94, annualizing to $7.2m for SFY'95.

Governor's Inter-Agency Task Force on Mixed Populations in Elderly and Disabled Housing: Preserving Existing Opportunities

In 1993, Governor Weld vetoed state legislation to impose a cap on the placement of physically and mentally disabled people in state-funded elderly housing complexes. In addition to limiting opportunities for the homeless in the housing complexes, implementation of this legislation was also expected to result in careless and unwarranted evictions, actually contributing to homelessness among those with mental illness. To deal with the concerns of the elderly and housing management communities regarding potentially disruptive residents, the governor convened an inter-agency task force to review

the situation, devise ways to minimize and mitigate tenancy problems, and identify alternative housing options and resources.

The task force included representatives from DMH, the Executive Offices of Elder Affairs, Communities and Development, Health and Human Services and its relevant agencies, Public Safety and MHFA. It issued a report containing findings and recommendations in response to the governor's directive, including short and long term measures.

Short term initiatives are focused on improving the tenancy application process and on supporting successful tenancies, for example by promoting the use of on-site service coordinators. Long term recommendations include conducting a housing needs assessment of persons with disabilities, identifying alternative housing models and resources, and other steps to alleviate problems, stabilizing housing developments and building relationships and ultimately communities between the elderly and disabled residents.

The task force recommended continued support and monitoring of the Services Coordinators Pilot Project described below.

Service Coordinator Pilot Project

In response to the current national and local debate regarding the mixing of elderly and disabled tenants in public housing, a study group was established by Massachusetts State Senator Frederick Berry. One of the recommendations of this group was the creation of a pilot project to test the effectiveness of placing "service coordinators" in mixed population housing. DMH has served as the convenor of an interagency steering committee for conducting the pilot.

The pilot project was implemented by a committee of seven state agencies, including DMH and EOCD. Together these agencies represent the spectrum of tenants living in mixed population housing. The purpose of the pilot was to determine the magnitude of tenancy-related problems, and the cost and benefits of funding service coordinators on-site who could serve elderly and disabled residents. The coordinators were in part charged with preventing tenancy problems and unwarranted evictions through appropriate and early intervention on tenant behavior problems. DMH, EOCD and MHFA provided the funding to hire the service coordinators, as well as case managers in two of the larger sites.

Boston Homeless Employment Pilot

DMH entered into a formal agreement with the U.S. Department of Labor funded Massachusetts Department of Employment and Training to provide employment services to approximately 80-100 formerly homeless and mentally ill individuals.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Planning

GOAL VIII/1: WORK WITH ADVOCATES AND OTHER STATE AGENCIES TO PLAN EFFECTIVELY FOR THE NEEDS OF PEOPLE WITH MENTAL ILLNESSES WHO ARE HOMELESS (HMI).

SHARED OBJECTIVE

Objective VIII/1a-S: **Begin to implement CCSS plans for each natural service area of the state, including a strategy within each CCSS to meet the needs of HMI based on the Action Plan.**

Indicators VIII/1a-S:

- CCSS plans for each natural service area of the state are developed. Each plan includes a preliminary strategy to meet the needs of HMI based on the Action Plan. **Accomplished**.
- DMH is working to ensure that each of the strategies is comprehensive and viable, by consulting with DMH Area Office housing staff and providing them with technical information. **Accomplished**.
- Meetings are held, at the local and central office level, between DMH and state agencies, consumer groups, providers and others to gain their input into statewide homeless policies and programs. **Accomplished**.
- Homeless projects are established in different parts of the state. **Accomplished**.

Comparison: In SFY'93, no CCSS plans, and therefore no comprehensive Area by Area housing strategies, were available. Prior to SFY'94, no statewide activity in this area existed.

Narrative: DMH has committed itself to a comprehensive homeless prevention as well as treatment strategy. This effort has policy development and planning as well as program elements.

ADULT ONLY OBJECTIVES

Objective VIII/1b-A: **Use funds available through the SFY'94 supplemental budget ($3.3m, available for several months of SFY'94, annualized to $7m in SFY'95) in accordance with the Interagency Action Plan, including eight projects in Metro Boston and six in other areas of the state. Provide housing and support services to enable 315 persons to move out of generic shelters.**

Indicators VIII/1b-A:

- With $11m in state appropriated funds, special initiative projects are being implemented in Boston, Worcester, greater-Springfield, Quincy, greater-Beverly and lower Cape Cod. **Accomplished**.
- Most projects are tied to HUD McKinney Act and other outside housing assistance awards totaling over $22m. **Accomplished**.
- DMH provides services to homeless individuals with mental illness and places a substantial number of them in housing situations. **Accomplished**.
- The governor submits a supplemental budget request to add to DMH's capacity to serve this population. **Accomplished**.

Comparison: Prior to SFY'94, DMH was not providing direct services to the homeless mentally ill through as many special projects, nor had the state leveraged as much in HUD and outside housing assistance for the homeless. In SFY'94, DMH provided services to 441 homeless mentally ill individuals, while placing 312 people in housing.

Narrative: Each project consists of comprehensive outreach and treatment services. All projects have been developed in conjunction with local service delivery agencies and housing providers, usually affiliated with local housing authorities or municipal community development departments.

Based on DMH's experience with the earlier initiatives, the governor submitted a $2.1 million request for supplemental funds for part of SFY'95 and beyond.

Objective VIII/1c-A: **Implement Capital Pooling legislation, passed in 1993, that provides up to $10 million to meet the housing needs of HMI.**

Indicators VIII/1c-A:

- Guidelines and regulations for the new program are devised. **Accomplished**.
- Briefing materials on the program are developed and delivered to DMH central and local office housing staff. **Accomplished**.
- Agreements between DMH, state agency partners and the state's key housing development agencies, for providing technical assistance to DMH local offices and housing providers to enable them to fully utilize the program, are finalized. **Accomplished**.

Comparison: Capital Pooling legislation was passed in late 1993. Statewide implementation activities were undertaken in SFY'94.

Narrative: In addition to undertaking general implementation and technical assistance activities, DMH was able to support three housing projects for Chapter 52 financing assistance.

GOAL VIII/2: INTEGRATE CONSUMERS WHO HAVE BEEN HOMELESS INTO THE GENERAL MENTAL HEALTH SYSTEM.

ADULT ONLY OBJECTIVES

Objective VIII/2a-A: **Implement a comprehensive homeless services program in the Metro Boston Area, and in Quincy, Lower Cape Cod, Springfield, Worcester and the Northeast Area to serve 315 HMI individuals using the following: permanent and transitional housing with support services; community outreach and treatment teams; post-crisis transitional housing; multi-service center for HMI; staff and consumer training/planning.**

Indicators VIII/2a-A:

- DMH homeless services projects are operating in the Metro Boston Area, Quincy, Lower Cape Cod, Springfield, Worcester and the Northeast Area. **Accomplished**.
- Each project offers a range of generic DMH services, through local DMH units and providers. Services include: outreach, stabilization, medication, crisis intervention, counseling, case management, permanent and transitional housing with support services. At least 315 homeless persons throughout the state receive services. **Accomplished**.
- The DMH Metro Boston Area Office employs community treatment teams in each CCSS. These teams provide critically needed services in a strategic fashion to homeless individuals with mental illness. **Accomplished**.
- The DMH Metro Boston Area program includes consumer employment components, including training consumers as case management aides. **Accomplished**.

Comparison: Prior to SFY'94, DMH was sponsoring homeless projects in the Metro Boston Area but not in the other cities mentioned. In addition, past services were not as closely linked with housing development.

Narrative: DMH will continue to sponsor its successful homeless initiatives through annualized funding in SFY'95. In addition, the Department hopes to obtain additional funding (new money) for more projects from the legislature in SFY'95.

Objective VIII/2b-A: **Implement a Services Coordinator Pilot Project ($125,000) in Boston, Brockton, Cambridge, Lynn and the North Shore. Test the effectiveness of placing service coordinators in public and**

assisted housing communities where elders and people with disabilities live, to promote effective intervention and services delivery, foster harmonious integration between elderly and younger disabled residents and prevent unnecessary evictions and homelessness among the disabled due to tenancy problems.

Indicators VIII/2b-A:

- Service coordinators in pilot projects in Boston, Brockton, Cambridge, Lynn, and the North Shore provide outreach to residents, intervene in crisis situations, make referrals to appropriate social service agencies as necessary, and act as the liaison between the housing manager and the network of social service agencies. **Accomplished.**
- Local multi-disciplinary teams are established by some of the service coordinators to access services outside of the mental health system, similar to the multi-assessment teams found in elderly congregate housing. **Accomplished.**
- A formal evaluation of the pilot is conducted by the McCormack Institute of Public Affairs at the University of Massachusetts/Boston. **Accomplished.**

Comparison: The pilot program was new for DMH in SFY'94 and prior to its implementation, no such activities existed.

Narrative: The success of the pilot program has helped to clarify the fact that the residents of public and assisted housing who exhibit the most behavioral difficulties are not those with mental illness. The program also helped to alleviate unnecessary evictions of tenants with troublesome behavior through timely service interventions. The McCormack Institute evaluation report found the project to be exceptionally successful in meeting expectations and objectives. The pilot's success led the governor to draft legislation in late SFY'94 to create a statewide services coordinator program. That legislation has been filed for the 1995 session.

<u>CHILD ONLY OBJECTIVE</u>

Objective VIII/2c-C: **Continue to assure that each CCSS plan explicitly addresses the needs of homeless children and their families and articulates an implementation strategy to meet those needs.**

Indicator VIII/2c-C: Review each CCSS plan to assure inclusion of appropriate planning for homeless children. **Accomplished.**

Comparison: There were no CCSS plans in SFY'93.

Narrative: In the course of the local CCSS planning process and in developing Area Housing Plans, DMH was unable to identify significant numbers of homeless children whose emotional disturbance was of such severity as to meet DMH criteria for intensive services, warranting the development of specialized plans or programs by DMH. The Department of Social Services (DSS) is the state agency charged with responsibility for homeless children, and DMH maintains links with DSS amd the Department of Public Welfare to ensure that any homeless children who cannot adequately be served by DSS are identified and referred to DMH.

REQUIREMENT #IX: **In the case of children with a serious emotional disturbance, the State plan-shall provide for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which system includes services provided under the Individuals with Disabilities Education Act); shall provide that the grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services; and shall provide for the establishment of a defined geographic area for the provision of the services of such system.**

Massachusetts has continued to advocate and participate in multiple forums for development of an integrated system of care for children and adolescents. Although the ultimate emergence of such a system depends on the willingness of the Executive Office of Health and Human Services, all of its constituent agencies and the legislature to make legal regulatory and policy changes, the agencies have all agreed upon the necessity for system reform and continue to meet regularly to address implementation issues.

Interagency Coordination

GOAL IX/1: THROUGH INTERAGENCY COORDINATION AND COLLABORATION, FACILITATE DEVELOPMENT OF A SEAMLESS SYSTEM OF CARE AT THE LOCAL LEVEL.

Objective IX/1a-C: Assure that each CCSS plan includes a specific implementation plan for addressing interagency concerns and transitional service needs.

Indicator IX/1a-C: Each plan includes specific goals related to interagency coordination, and to means of assuring appropriate care for adolescents becoming too old for child/adolescent mental health services. **Accomplished.**

Comparison: Requiring that interagency collaboration and planning for transition-age youth be included in each Area's plan has clarified and highlighted the resources and the systems' restructuring necessary for significant progress in these Areas.

Narrative: Block grant funds were used in SFY'94 to establish new interagency initiatives for children and adolescents in the Metro West and Metro Boston Areas and to create additional housing for youth 18-25.

GOAL IX/2: CONTINUE TO DEVELOP, UNDER THE AUSPICES OF THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS), AN INCREMENTAL AND TRANSFORMATIVE MULTI-YEAR PLAN THAT WILL RESULT IN AN INTEGRATED SYSTEM OF CARE FOR CHILDREN SERVED BY PUBLIC AGENCIES.

Objective IX/2a-C: Assess regulatory, statutory and policy obstacles, barriers and reverse incentives to develop an integrated service system.

Indicator IX/2a-C: DMH contributes to a report prepared by the EOHHS Children's Services Integration Committee outlining regulatory, statutory, policy barriers and reverse incentives to systems integration. **Accomplished**.

Comparison: A more systematic approach to addressing the obstacles that impede service integration was developed in SFY'94. This review of obstacles was the groundwork for the workplan for systems integration described below under Objective IX/2b-C.

Objective IX/2b-C: Develop, in collaboration with other child-serving agencies, a proposal for presentation to the Secretary of EOHHS that addresses the following issues:

- **creation of a unified case management system;**
- **creation of a cross-agency information and referral system that will function statewide and address all children's service issues;**
- **definition of thresholds for out-of-home placement;**
- **creation of a standardized initial assessment and referral protocol;**
- **clarification of the roles and service responsibilities of each child-serving agency;**
- **development of procedures to ensure joint program planning;**

- **creation of a mechanism for pooling dollars to purchase individualized services;**
- **development of shared training initiatives.**

Indicator IX/2b-C: A report and projected workplan is presented to the Secretary of EOHHS which addresses the issues outlined in the above objective. **Accomplished**.

Comparison: The workplan represents the first time there was a formal, articulated plan agreed upon by all the child-serving agencies which outlined specific steps, with timelines, to promote integration of children's services.

Narrative: The April 7, 1994 workplan created by the Children's Services Integration Committee was accepted by the Secretary of EOHHS in spring, 1994. Work has begun on the development of a collaborative intake, assessment and triage process, a single point of entry to children's services. A specific proposal for intake, assessment and triage will be developed in SFY'95. Interagency planning continues at the local level as well. The agencies in western Massachusetts submitted an application for a Services Demonstration Project to the Center for Mental Health Services that reflected the principles of the statewide Children's Services Integration Committee as adapted to reflect the service configuration and cultural context of the Holyoke Area.

REQUIREMENT #X: The State plan shall describe the manner in which mental health services will be provided to individuals with a serious mental illness or emotional disturbance residing in rural areas.

The Department has begun to implement CCSS plans to increase service accessibility for persons in more rural areas by increasing transportation services, by decentralizing services, and by making some services mobile.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Access to Services

GOAL X/1: INCREASE ACCESS TO SERVICES FOR PERSONS IN RURAL AREAS.

Objective X/1a-S: Implement CCSS plans relative to increasing the ability of programs to provide services where consumers are located rather than at a fixed location, for example: mobile case management, mobile supported employment services and additional DMH (natural service area) satellite offices.

Indicators X/1a-S:

- CCSS Plans are submitted and identify strategies for addressing access issues. **Accomplished**.
- Areas begin implementation of CCSS plans. **Accomplished**.
- The designation of satellite offices is completed following an assessment of a number of demographic concerns, including transportation patterns/ availability and accessibility of services. **Accomplished**.

Comparison: The CCSS Plans were submitted in SFY'94. They represented the result of a year of system review and needs assessment involving hundreds of stakeholders to determine the degree to which local service needs were being met. Such plans did not exist in SFY'93. Although services existed in all Areas, the CCSS planning process established a standardized process for review of those service systems based upon a single set of standards which were articulated in the CCSS Guidance Manual. Access to services was an especially critical element of the review. Many Areas with rural communities have developed service designs which are based on mobile outreach models (i.e. Mobile Community Treatment, Mobile crisis intervention services, etc.).

Narrative: The objective was fully met with the submission and implementation of the CCSS plans. It was determined there is no need at this time to increase satellite offices. It is important to note, however, that the CCSS planning process is an ongoing initiative. It did not end with the submission of the plans. Systems change, needs change, and strategies to meet those needs change, so the Areas will continue to assess and reassess their service systems.

Objective X/1b-S: Implement CCSS plans to improve transportation services for persons living in rural areas, through advocacy with local transportation authorities (schedule and route changes) and through increasing program related transportation as Area budgets permit.

Indicator X/1b-S: CCSS Plans identify strategies to address transportation issues. **Partially Accomplished**. (See Narrative below)

Comparison: In SFY'93, the CCSS planning process was underway but the CCSS plans were not submitted until SFY'94.

Narrative: This objective was not fully accomplished because one of the Areas with a significant rural population (Western Mass.) did not thoroughly address the problem in its plan. The Western Mass. Area plan was approved with the requirement that a Corrective Action Plan be submitted which specifically addresses the transportation issue and presents strategies for resolution. At the end of SFY'94, the Area was in the process of developing that Corrective Action Plan.

The transportation issue is being addressed primarily through advocacy with transportation authorities, better coordination of available transportation resources in DMH contracts, the development of local transportation task forces, etc. In one Area, (Metro South), the Area funded the start-up of a consumer-owned business which provides transportation for other consumers to services, work, appointments, etc. The business is totally operated by consumers. All Areas have reviewed this issue, not just the rural areas.

REQUIREMENT #XI: The State plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.

GOAL XI/1: USE NATIONAL AND STATEWIDE DATA TO ESTIMATE THE NUMBERS OF ADULTS AND CHILDREN, INCLUDING THOSE WITH UNIQUE NEEDS, IN EACH DMH AREA, WHO REQUIRE PUBLICLY FUNDED SERVICES.

Please note: Goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their shared applicability; goals and objectives relevant to *only one* of the systems will be coded as (A) for adults and (C) for children and adolescents.

Quantitative Estimates of Size of Target Population

SHARED OBJECTIVE

Objective XI/1a-S: Use Center for Mental Health Services methodology to calculate incidence and prevalence of serious mental illness and severe emotional disturbance for adults and children in the state.

Objective XI/1b-S: Promulgate child/adolescent prevalence estimates that reflect current expert thinking and the limited research results available.

Indicators XI/1a&b-S: National prevalence methodology and standards are developed by the Center for Mental Health Services and are used to adjust the Massachusetts procedures for estimating prevalence of serious mental illness and severe emotional disturbance for adults and children in the state. **Not accomplished.**

Comparison: In 1990, A DMH task force on Incidence and Prevalence considered alternative procedures for measuring mental health needs in DMH Areas. The task force reviewed research findings and made recommendations for the final estimation procedures. This work resulted in the adoption of prevalence estimates DMH has used since then for planning purposes. In SFY'93, using the same methodology, DMH revised the estimates for adult prevalence based on updated (1990) census information that became available in 1993. Estimates for child/adolescent prevalence were not revised. Since DMH did not receive guidance from CMHS during SFY'94 regarding a new, acceptable methodology, no revisions were made to either the adult or child/adolescent estimates. When these are received, the prevalence estimates will be revised.

Narrative: The following chart summarizes DMH prevalence estimates:

Area	Adults with Severe Mental Illness & Severe Dysfunction (0.98%)	Children and Adolescents (5%)
Western Mass	6,815	5,115
Central Mass	5,147	4,011
Metro West	3,609	2,404
Northeast	8,864	6,412
Metro Boston	8,838	8,585
Metro South	3,600	2,390
Southeastern Mass	7,858	6,624
Statewide	44,730	35,540

For planning purposes, DMH considers there are 22,365 adults who may need publicly funded mental health services and 35,540 children under age 19 who are likely to need public mental health services from DMH or one of the other child-serving agencies that share responsibility for providing mental health services.

A special problem exists with respect to child/adolescent prevalence estimates. There is not at present a national research data base to support empirically derived estimates of the numbers of children and adolescents with serious emotional disturbances. DMH currently uses estimates based on studies conducted in North Carolina and Florida.

Objective XI/1c-S: Develop a plan and procedures to use prevalence estimates as basis for developing Area-based equity funding.

Indicator XI/1c-S: A plan and formulas are developed, based on prevalence estimates, for use in setting allocations and spending plans for SFY'95. **Accomplished**.

Comparison: No plan existed in SFY'93. This project evolved as part of SFY'94 CCSS planning and the establishment of Area and CCSS budgets.

Narrative: Prevalence estimates were used to compare service penetration rates across service Areas, including case management, residential services and inpatient care. It was determined that as additional resources become available, either through savings or increased appropriation, the formulas will be used to more equitably distribute resources. The formulas are also an aid in balancing the effects of any funding reductions.

REQUIREMENT #XII: The State plan shall contain a description of the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved to carry out the provisions of the plan in the foregoing requirements (I - XI).

In accordance with Public Health Services Act Section 1917 (a), Part B, Title XIX, the Massachusetts Department of Mental Health is submitting this annual report of its activities under the mental health portion of the ADMS Block Grant. The attached analysis provides a description of state activities under the block grant and a summary of the purposes for which block grant funds were spent for the federal fiscal year 1993 award.

Summary of Programs and Funding

A. ALLOCATIONS

Table I is a summary of mental health block grant funding in Massachusetts. Funds awarded in a given federal fiscal year may be expended during more than one state fiscal year for two reasons. First, block grant funds are expended on the state fiscal year (SFY) cycle (July 1 to June 30), which differs from the federal fiscal year (FFY). Secondly, federal legislation requires a state to commit funds within the first year of the grant and spend the funds within two years of the grant award. Therefore, the following tables represent how FFY'93 block grant resources were expended over the SFY involved.

TABLE I

APPLICATION	FED FY	STATE FY	AMOUNT
1	82	81-84	$9,266.044
2	83	84-85	$10,237,607
3	84	85-86	$10,106,839
4	85	86-87	$10,106,839
5	86	87	$10,106.839
6	87	87-88	$10,338,453
7	88	88-89	$10,106,839
8	89	89-90	$10,364,254
9	90	90-91	$9,609,228
10	91	91-93	$9,889,591
11	92	92-94	$9,889,591
12	93	93-95	$9,869,692

Table I shows the distribution of FFY'93 block grant funds by Area for the state. The seven DMH Area offices are responsible for contract management, monitoring and quality assurance for block grant funded programs.

TABLE II

DISTRIBUTION OF BLOCK GRANT FUNDS BY AREA
STATE FY'93-95

WESTERN MASS	40,000
CENTRAL MASS	1,539,112
NORTHEAST (Formerly Merrimack Valley & No.Shore)	4,146,939
METRO WEST AREA	665,135
METRO BOSTON AREA	1,401,103
METRO SOUTH AREA	621,325
SOUTHEASTERN AREA (Formerly So. Shore & So.West)	696,253
NEW CHILD/ADOLESCENT INITIATIVES	507,780
STATEWIDE INITIATIVES	759,825
TOTAL	9,869,692

(Note: Area totals include integrating FFY'93 children's initiatives into the Area funds)

B. SERVICES FOR FFY'93 BLOCK GRANT

The block grant funds represent approximately 2% of the state's total support for community mental health services. These funds are targeted to a range of community mental health programs for adults with long term or serious mentally illness, children and adolescents with severe emotional disturbances, and traditionally undeserved populations, such as cultural/linguistic minorities.

Services supported by the block grant are an integral part of the community mental health service delivery system and an important means of developing a comprehensive service system for all individuals in need of publicly funded services.

The Department of Mental Health is mandated to target service delivery to the most seriously ill citizens of the Commonwealth. The emphasis is on programs that maximize the independent functioning of these consumers through an array of services providing support and structured skills development. Services provided in the community are designed to decrease inappropriate hospitalization by providing sufficient support to enable individuals to be successfully maintained outside of inpatient settings.

The community service system reflects the Department's commitment to provide emergency or short term treatment for any person experiencing an acute mental health disorder, as well as long-term services for the Department's priority consumers.

The conceptual framework for mental health services recognizes that the mental health needs of individuals are unique and change over time. In order to respond to these changing needs, the service system must be flexible and offer

treatment for symptoms of mental illness, as well as rehabilitation and supportive services to assist each individual in coping with the functional disabilities resulting from his/her illness.

The goal of the Massachusetts service delivery system is to assist consumers to achieve and maintain the highest possible level of functioning so that they may live and work in the communities of their choice. To reach this goal, a range of treatment and psychiatric rehabilitation services must be available for DMH priority consumers. This range includes emergency, case management, day/vocational, residential, outpatient, and peer and family support services. **Table III** lists the program types the Department uses in developing a system of community services to respond to consumers' needs.

The block grant provides an important means for the Department to develop a fully comprehensive service system. By supporting the development of new programs and services where needed, the block grant provides critical assistance to DMH in developing a system of community services. DMH uses the same competitive procurement mechanisms for handling federal funds as for state funds. Contracts are developed at the Area Offices.

Table III lists the SFY'94 level of direct care services supported by the FFY'93 block grant. Each Area receiving block grant funds, under the direction of an Area Director, is responsible for determining the level and types of services to be supported. Each Area plans and develops a service system most appropriate and responsive to the needs of the Area's consumers. **Table IV** indicates the amount of block grant funds spent on direct care services by each Area.

Sections 1916(b) and 1913 (a) include "set-aside" provisions which specify targets for administrative expenses and children's services in FFY'93. Briefly summarized, these requirements are as follows:

- Not more than 5% of block grant funds will be used for administration.
- At least 20% of block grant funds will be used for children's services.

Inspection of Table III indicates that the Department is currently in compliance with the first requirement listed above. A total of 2.27% of block grant funds were used to support administration. The Department feels it is also in compliance with the second requirement. While Table III indicates slightly more than 18% of the funds were used to support contracted services to children and adolescents, DMH estimates that, in fact, at least 21.75% of the dollars are used for children's services. As DMH has an integrated service system, the Department estimates that at least 10% of the total shown as mixed services, equal to 3.75% of the total block grant, are used for children and adolescents.

TABLE III

State FY94 Expenditures for FFY93 Grant Award

Program Code	Description	SFY94 %	Actual Expenditure State FY94
3002	Fiscal	0.00%	0
3005	Legal	0.18%	13,453
3006	Office Administration	0.31%	22,452
3007	Program Support	0.30%	22,036
3023	Research	1.48%	107,469
	Subtotal Administration	2.27%	165,410
3032	Case Management	0.00%	0
3033	Skills Training	7.81%	568,635
3034	Community Support Clubhouse	4.70%	342,094
3035	Supported Employment	1.26%	91,615
3040	Specialized Residential	0.84%	60,850
3041	High Intensity Residence	0.00%	0
3042	Moderate Intensity Residence	0.00%	0
3043	Low Intensity Residence	0.00%	0
3044	Satellite Residence	2.13%	155,000
3045	Supported Housing	0.00%	0
3050	Out Patient	0.77%	56,172
3051	Psychiatric Day Treatment	5.22%	380,211
3053	Drop-In Center/Social Club	0.00%	0
3054	Consumer/Family Support	0.56%	40,913
3055	Community Support	18.67%	1,359,101
3056	Individual Support	0.22%	16,197
	Subtotal Adult Services	42.18%	3,070,788
3030	Expanded Child/Adolescent (DEST	0.00%	0
3061	Home Based Treat & Crisis Intv	11.56%	841,301
3063	Mobile Clinical Community Treatm	0.27%	20,000
3064	OutPatient Services	1.64%	119,407
3065	Comm &School Therap Support	0.98%	71,068
3066	Specilized Intervention for Children	1.10%	79,961
3070	Emergency Shelter	2.26%	164,833
	Mobile Diversion Team	0.00%	0
3071	Crisis Respite/Therapeutic Foster C	0.00%	0
3073	Resdential Treatment II	0.22%	15,836
3074	Resdential Treatment III	0.00%	0
	Subtotal Children's Services*	18.03%	1,312,406
3020	Comprehensive Staff Training	0.00%	0
3021	Psychiatric/Residency Training	0.00%	0
3022	Multi-Disciplinary Training	0.45%	32,708
3030	Crisis Intervention **	36.04%	2,623,360
3031	Emergency Shelter	0.00%	0
3052	Forensic Evaluation	1.03%	74,977
	Training Providers (Grants Mandate	0.00%	0
	Consumer&Expatient Initiative	0.00%	0
	Subtotal Mixed Services*	37.52%	2,731,046
	Total Services	100.00%	7,279,649

** Crisis Intervention includes services rendered for Child/Adolescent Services

TABLE IV
FFY93 BLOCK GRANT EXPENDITURES
COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS

WESTERN MASS AREA James Duffy, Ph. D., Area Director P.O. Box 389 Northampton, MA 01061 (413) 784-1790	Total FFY93 Expenditures:	$39,961
CENTRAL MASS AREA Constance Doto, Area Director Worcester State Hospital 305 Belmont Street Worcester, MA 01604 (508) 752-4681	Total FFY93 Expenditures:	$1,025,569
NORTHEAST AREA Lorene Bourque, Interim Area Director P.O. Box 387 Tewksbury, MA 01876 (508) 851-7321	Total FFY93 Expenditures:	$3,247,708
METRO WEST AREA Theodore Kirousis, Area Director Westborough State Hospital P.O. Box 288 Lyman Street Westborough, MA 01581 (508) 792-7400, x207	Total FFY93 Expenditures:	$488,187
METRO BOSTON AREA Clifford Robinson, Area Director 20 Vining Street Boston, MA 02115 (617) 727-4923	Total FFY93 Expenditures:	$1,017,059

METRO SOUTH AREA Barbara Leadholm, Area Director Medfield State Hospital 45 Hospital Road Medfield, MA 02052 (508) 369-7312 x600	Total FFY93 Expenditures:	$504,635
SOUTHEASTERN AREA John P. Sullivan, Ph. D., Area Director Brockton Multi-Service Center 165 Quincy Street Brockton, MA 02402 (617) 727-0827	Total FFY93 Expenditures:	$584,523
STATEWIDE INITIATIVES Valerie Fletcher, Deputy Commissioner for Program Operations Central Office 25 Staniford Street Boston, MA 02114 (617) 727-5500 x402	Total FFY93 Expenditures:	$372,007
TOTAL:		**$7,279,649**

Note: Additional expenditures are being incurred and expended during the state FY95.

1995 STATE MENTAL HEALTH PLAN

REQUIREMENT #I: The State plan shall provide for the establishment and implementation of an organized community-based system of care for adults with a serious mental illness and children with a serious emotional disturbance.

The Massachusetts Department of Mental Health (DMH) began a major restructuring of its service system in 1991 with the expressed goal of implementing an effective community-based system of care for adults with a serious mental illness and children with a serious emotional disturbance. Much has been accomplished. The closure of three adult state hospitals and the Gaebler Children's Center enabled DMH to reallocate more than $65 million in savings to community-based services, including the addition of 1,300 new residential beds, a redesigned emergency services system, increased alternatives to hospitalization such as crisis stabilization and respite beds, and increased home-based services for children. The Department provides continuing care for adults in its four hospitals, and in its one contracted latency age and three contracted adolescent inpatient units. Virtually all acute inpatient care for children and adolescents and most acute inpatient care for adults is provided in general or private psychiatric hospitals in communities across the Commonwealth with the remainder of acute care for adults provided in seven community mental health centers with small inpatient units. Hospital-based acute care in the community consists of a combination of DMH-contracted replacement units and Medicaid's mental health managed care network beds.

The challenge for DMH has been to establish standards of care and a state-of-the-art utilization management system. The development of uniform standards and the establishment of mechanisms to continuously assess and improve services will assure the provision of high quality, accessible and cost effective mental health services for the citizens of Massachusetts. The goals and objectives for SFY'95 build upon the quality management foundation established in the last two years by:

Decentralizing day-to-day responsibility for quality assessment and improvement activities from the Central Office of DMH to the field offices;

Operationalizing standards of care through accreditation, certification and performance-based contracting.

Requiring the establishment of Quality Councils at provider, Comprehensive Community Support System (CCSS) and Area levels.

The development and implementation of utilization management standards ensures that DMH resources are deployed as effectively and efficiently as possible.

Restructuring has also occurred at the organizational level. The community mental health system is overseen by seven DMH Area offices. Each Area office functions as a public managed care entity with responsibility through its case management function for facilitating linkage between all eligible consumers within its catchment area and available formal mental health as well as generic community services. Each Area office is also responsible for any state facility located within its area. The Area's budget includes line item funding for adult and child community services, inpatient services, forensic services and administrative support. The majority of community services are delivered by providers under contract to DMH, at the CCSS or Area level. DMH directly provides case management services for priority consumers, all forensic mental health services and a small amount of residential care. The governor's SFY'95 budget request to the legislature included a request for a new Area account structure that would have permitted Areas to have flexibility in transferring funds among their line item accounts, but this was rejected, restricting each Area's ability to move funds as needed between their inpatient and community programs.

Stakeholders, including consumers, family members, providers, advocates and staff participated in record numbers in all of the Department's planning activities. This participatory effort is basic to the Department's ongoing planning process which is structured to regularly produce three-year plans. Quality and utilization management initiatives are ongoing and require significant cultural change to fully implement. The Department also continues to invest in developing and supporting consumer initiatives, including consumer-run business ventures, coordinated by the Office of Consumer and Ex-Patient Relations (OCER). OCER reaches out to consumers, including children, adolescents and adults throughout the state to broaden their participation in DMH activities. One OCER staff member works exclusively on adolescent issues and outreach.

The Department is also invested in the work of its Multi-Cultural Advisory Committee, (MCAC) a group of 125 mental health professionals, providers, DMH staff, consumers and family members from a variety of cultural, ethnic and linguistic minority groups representing adults, children and adolescents. The MCAC has begun to implement initiatives developed during SFY'94. Implementation in SFY'95 will consist of outreach to consumers, family members, DMH staff and other professionals, education, developing a consensus and, subsequently, an action plan to further implement one of the committee's recommendations. Outreach will occur through invitations to participate in committee activities and meetings. Education concerning adults and children with mental illness will take place in a series of monthly Grand Rounds to be held in five strategic areas within the state, targeted specifically to various cultural groups. DMH staff and affiliates, as well as consumers, family and community members, will be asked to attend. The Multi-Cultural Advisory Research and Education Center subcommittee will meet to identify funding sources and develop a strategy to begin writing grant proposals.

Please note that in the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Regulations and Standards

GOAL I/1: ESTABLISH AN ORGANIZATION-WIDE QUALITY MANAGEMENT PROGRAM.

SHARED OBJECTIVES

Objective I/1a-S: Expand quality assessment and improvement activities to the CCSS and service delivery level.

Indicator: Two Area Offices establish Quality Councils at the CCSS level to measure, assess and improve CCSS performance.

Indicator: A standardized program assessment mechanism and standardized performance criteria are incorporated into the Department's bid guidelines for residential services.

Objective I/1b-S: Continue the implementation of provider self assessment in all Area Offices, as one component of the Department's quality assessment and improvement program, to ensure ongoing and systematic monitoring and evaluation of provider performance. Use self assessment for centrally managed child and adolescent programs.

Indicator: Quality improvement standards that outline expectations for provider self assessment activities are included in the Department's residential program standards.

GOAL I/2: IDENTIFY STANDARDS OF CARE FOR THE COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS.

SHARED OBJECTIVES

Objective I/2a-S: Maintain/expand certification and/or accreditation of state hospitals, inpatient units of state-operated Community Mental Health Centers, Intensive Residential Treatment Programs and Area Offices as mental health service delivery networks.

Indicator: All inpatient programs scheduled for an accreditation survey by the Joint Commission for the Accreditation of Healthcare Organizations in SFY'95 are awarded accreditation.

Indicator: Two Area Offices complete and submit survey applications to the Joint Commission for the Accreditation of Healthcare Organizations in order to pursue accreditation as mental health care networks.

Objective I/2b-S: Complete revision of residential program definition and adopt residential program standards of care.

Indicator: Revised residential program standards of care are reviewed by a focus group comprised of consumers, family members, DMH staff and staff for residential provider agencies prior to adoption by the Department.

Indicator: After adoption by the Department, the residential program standards of care are incorporated into the Department's bid guidelines for residential services.

GOAL I/3: ENSURE THAT THE STATUTES, REGULATIONS AND POLICIES THAT GOVERN THE DEPARTMENT OF MENTAL HEALTH ARE COMPATIBLE WITH PUBLIC MANAGED CARE AND THE MAINTENANCE AND EXPANSION OF COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS, WHILE CONTINUING TO PROTECT THE LEGAL AND HUMAN RIGHTS OF CONSUMERS.

Objective I/3a-S: Develop and implement a single program code for adult residential services and a single program code for child/adolescent residential services. These comprehensive codes will encompass generic components of residential services and allow for greater flexibility of evolving residential models, consistent with recommendations in the CCSS plans.

Indicator: Requests for Proposals (RFPs) for residential programs issued in SFY'95 (for SFY'96) are based on a program description of residential services encompassing the generic components identified in the Single Residential Program Code.

Objective I/3b-S: Continue work of task force to examine and recommend changes to the Department's enabling statute, MGL Chapter 19, that are consistent with the Public Managed Care initiative.

Indicator: Task force meets monthly and submits finished sections to Executive Staff for review and approval. Executive Staff approves a plan and date for legislative filing.

Objective I/3c-S: Continue systematic review of all DMH policies, and regulations as needed, to bring them into conformity with current statute and practices.

Indicator: At least five DMH policies are reviewed and are maintained, discarded or revised, as necessary. The Policy and Planning Committee sends recommendations regarding their disposition to Executive Staff.

Indicator: Work groups are formed, including outside interested parties when appropriate, to revise existing policies or create new ones.

Indicator: New or revised policies are distributed to the field and implemented.

Planning

GOAL I/4: ESTABLISH AN ADMINISTRATIVE STRUCTURE WHICH SUPPORTS DEVELOPMENT AND MANAGEMENT OF LOCALLY BASED COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS AS BASIS OF DMH PUBLIC MANAGED CARE.

SHARED OBJECTIVE

Objective I/4a-S: Continue to work with other mental health advocates, including individuals representing child, adult, elder, family, consumer and multicultural organizations, to focus on inclusion of coverage for mental health services in national health care reform; educate state and national legislators regarding Massachusetts' mental health system and the potential impact of proposed reforms on the state.

Indicator: Advocates meet and/or communicate on a regular basis; advocates send letters or visit legislators, as needed, as part of educational campaign.

Objective I/4b-S: Complete next phase of planning process for Comprehensive Community Support Systems (CCSS) in each of 33 natural service areas (NSA) of the state.

Indicator: A written evaluation and corrective action plan for each CCSS plan is completed for each Area.

Objective I/4c-S: Integrate NSA multi-year CCSS plans into new statewide multi-year plan.

Indicator: Approved CCSS plans are used to establish the priorities and budgets of the Areas and agency and are reflected in an annual report issued by the Commissioner.

Objective I/4d-S: Complete restructuring of Area offices to ensure that all Area offices and CCSS sites are appropriately staffed to carry out their functions (e.g., quality management, case management, medical director, fiscal and core services, community programs, program evaluation, human rights, etc.).

Indicator: Area specific standards, performance objectives, and performance indicators are completed annually for each Area and for each Area Director.

Objective I/4e-S: Resources are redistributed, as necessary, in conjunction with Comprehensive Community Support System needs assessment and staffing analysis, to ensure that funded services are in line with consumer need and preference.

Indicator: CCSS plans indicate how funds will be distributed to meet each Area's stated objectives.

Objective I/4f-S: Evaluate resource equity issues, in conjunction with Comprehensive Community Support System analysis and equity formula, and develop long-term plan for reconciling equity issues.

Indicator: Annual budgets are developed for each CCSS, based on need and equity.

Consumer and Community Involvement

GOAL I/5: ENSURE THE CONTINUED PARTICIPATION OF CONSUMERS AND FAMILY MEMBERS, INCLUDING PARENTS OF CHILDREN AND ADOLESCENTS, AND MEMBERS OF RACIAL AND LINGUISTIC MINORITY GROUPS, AT THE CCSS, AREA AND CENTRAL OFFICE LEVELS OF DMH.

SHARED OBJECTIVES

Objective I/5a-S: Continue Office of Consumer and Ex-Patient Relations (OCER) activities to expand participation of adult and adolescent consumers and parents of children.

Indicator: A consumer newsletter, written and compiled by consumers is published at least quarterly and distributed statewide.

Indicator: New consumer-run initiatives/businesses are developed and both new and ongoing consumer-run initiatives are developed and funded.

Indicator: A 24/day toll-free Information and Referral (voice mail) service is maintained, with live operator available 25 hours/week.

Indicator: Consumers and family members are included on DMH task forces. DMH regulations include the requirement that each citizen advisory board has consumer and family member participation and appropriate appointments are made.

CHILD ONLY INDICATOR

Indicator: The organizer for adolescents hired by OCER has regular contact with this constituency and advocates for the needs, preferences and perspectives of adolescents while helping them move towards self-advocacy.

Indicator: A library of materials for parents regarding child and adolescent mental health issues is maintained.

SHARED OBJECTIVES

Objective I/5b-S: Continue the work of the Multi-Cultural Advisory Committee (MCAC) to expand access to mental health services for people of color and cultural and linguistic minorities. (ongoing)

Indicator: The DMH Client Registry is analyzed to determine whether or not increased numbers of people of color, cultural and linguistic minority groups are being served.

Objective I/5c-S: Incorporate Grand Rounds throughout the state to focus on cultural and linguistic treatment issues, as a first step in ongoing education regarding services for people of color.

Indicator: Six Grand Rounds are held, beginning September 1994.

Objective I/5d-S: Continue to explore mechanisms to fully actualize a Multi-Cultural Mental Health Research Center.

Indicator: Identify funding sources; develop a plan to write the proposal.

Objective I/5e-S: Meet with DMH administrators throughout the state; restructure MCAC's teams to prepare for phased implementation of the committee's recommendations.

Indicator: Meetings are held; restructuring plan is written.

REQUIREMENT #II: The State plan shall contain quantitative targets to be achieved in the implementation of an organized community-based system of care, including the numbers of individuals with serious mental illness or serious emotional disturbance residing in the areas to be served under such system.

Key to the success of the DMH Public Managed Care initiative is the presence of management information systems and applied technology to provide the Department with comprehensive data, including reliable information on the population served.

The Department is not presently able to produce an unduplicated count of all consumers served. However, it estimates that 75,000 people, including 10,000 children, will receive services provided or contracted for by the Department. This number includes both DMH priority consumers and others who use the DMH emergency system and other short-term services. A statewide client registry contains the names of all individuals receiving case management services, residential services that have been certified by DMH as eligible for Medicaid reimbursable "rehab option" billing (this represents about 85% of residential slots) and inpatient services (in state hospitals, state-operated community mental health center inpatient units and DMH-contracted replacement units in general and private psychiatric hospitals). It also provides a detailed tracking system for case managed consumers. Although the number of individuals receiving each of these services is unduplicated, there is overlap among the service types. At the present time, DMH does not have the technical capability to count the **number of individuals** who receive services in other community programs, only the program capacity.

To meet the information needs for the future, a project was initiated in SFY'94 to expand information about consumers using DMH services, reduce duplication by use of a single management information system and provide enhanced statistical and quantifiable data through use of current technologies. The system targeted to meet this need is the Registration and Enrollment

System (RES). This is a multi-year project with specified objectives to be accomplished in SFY'95. When completed, the RES will encompass all consumers receiving services provided and/or funded by DMH, including contracted community programs.

The goal in SFY'95 is to maintain the staffing levels required to provide at least the amount of service provided to consumers in SFY'94, including services for special and sub populations. These special groups include: deaf and hard of hearing, elderly, dually diagnosed and forensically involved consumers. However, demand for a particular service or a significant change in resources available may cause the numbers of individuals served to change, up or down.

DMH has a division of forensic mental health services that manages the assessments and provides consultation regarding care for adults and children with mental illness or serious emotional disturbance who become involved with the criminal justice system. The development of a forensic inventory and data base continues to enhance the Department's ability to make more accurate assessments of the numbers and types of patients committed to the DMH inpatient system under the forensic sections of the Mass. General Laws, enabling treatment teams to assure a standard of forensic care and mental health treatment that is in line with national expectations.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Targeted Population to be Served

GOAL II/1: IDENTIFY AND PLAN SERVICES FOR ELIGIBLE CONSUMER POPULATIONS.

SHARED OBJECTIVE

Objective II/1a-S: Determine the number of consumers to be served in each DMH Area, based on each Area's approved (SFY '95) CCSS plan.

Objective II/1b-S: Maintain staffing levels required to serve at least the same number of adult and child/adolescent consumers served in SFY'94.

Indicator: Planning population estimates will be established using accepted statistical modeling techniques for determining prevalence estimates of mental illness. When federal incidence and prevalence indicators are available, these will be incorporated into ongoing planning efforts.

The Department expects to be able to serve the same number of consumers in SFY'95 in these categories of service (case management, inpatient and residential/rehab), based on current staffing capacity and need.

Indicator: Adult Consumers to be Served in SFY'95

DMH Area	Case Management	Inpatient	Resid/Rehab/Option
Metro Boston	1,083	1,342	728
North East	1,832	529	691
Southeastern	2,457	587	811
Metro West	994	1 55	489
Metro South	944	220	339
Central Mass.	1,209	416	637
Western Mass.	1,317	378	617
Total	**9,836**	**3,627**	**4,312**

Please note: "Inpatient" for adults always refers to patients in state-operated community mental health center (CMHC) inpatient units and DMH-contracted replacement units in general and private psychiatric hospitals; the Western Mass., Central Mass. and Metro West Areas do not have state-operated CMHCs;

Indicator: Children Under 19 to be Served in SFY'95

DMH Area	Case Management	Inpatient	Resid/Rehab/Option
Metro Boston	317	33	44
North East	288	37	70
Southeastern	388	36	40
Metro West	81	15	22
Metro South	96	10	13
Central Mass.	168	15	48
Western Mass.	178	25	87
Total	**1,516**	**171**	**324**

Please Note: There are no DMH-operated inpatient units for children. The numbers for children under 19 above represent continuing care admissions to one contracted replacement unit for latency age children and three contracted adolescent units. DMH does not contract for acute care beds. Children and adolescents receive acute care in general and private hospitals, funded through insurance, Medicaid or free care.

Objective II/1c-S: Maintain staffing levels required to serve the same number of adult and child/adolescent deaf and hard of hearing consumers served in SFY'94.

Indicator: Deaf and Hard of Hearing Consumers to be Served in SFY'95

DMH provided case management services to 46 deaf individuals (includes one adolescent and 45 adults) in SFY'94. This targeted population of DMH priority consumers had a combined total of 80 inpatient admissions to all inpatient facilities in SFY'94 and 35 of these consumers received a total of 43 residential placements. DMH tracks inpatient admissions of this group to all CMHCs, replacement units and private hospitals and to the 10-bed unit for deaf consumers at Westborough State Hospital run by the UMass Medical Center.

DMH provided case management services to 68 profoundly hard of hearing individuals (includes two adolescents and 66 adults) in SFY'94. This targeted population of DMH priority consumers had a combined total of 102 inpatient admissions to all inpatient facilities in SFY'94 and 60 of these consumers received a total of 88 residential placements.

DMH expects to provide case management services to 114 deaf or hard of hearing consumers in SFY'95, based on current staffing capacity and need. (**Note:** These consumers are also included in other service target numbers.)

Objective II/1d-S: Maintain staffing levels required to serve at least the same number of dually diagnosed adults, children and adolescents served in SFY'94.

Indicator: Adults with Mental Illness/Co-Occurring Psychoactive Substance Use Disorder to be Served in SFY'95

The Department estimates that 35% of the overall adult planning population (including elders) have active or intermittently active substance abuse problems as do 55% of those admitted for inpatient care. Therefore, of those DMH consumers included in the Client Registry, we apply these percentages, to each of the respective service types, to estimate adult target population with Psychoactive Substance Use Disorder (PSUD).

DMH Area	Case Managed/ PSUD	Inpatient/ PSUD	Resid/Rehab/Option/ PSUD
Metro Boston	379	738	255
North East	641	291	242
Southeastern	860	323	284
Metro West	348	85	171
Metro South	330	121	119
Central Mass.	423	229	223
Western Mass.	461	208	216
Total	**3,442**	**1,995**	**1,510**

DMH expects to be able to serve 3,442 case managed individuals with co-occurring substance use disorders, 1,995 inpatients and 1,510 through (certified "rehab option") residential services in SFY'95 based on current staffing capacity and need. There is overlap among the consumers receiving these services. For a definition of "inpatient", see above. **Note: Changes in the number of people receiving case management, the basis for the Client Registry, may result in changes in the overall percent of PSUD consumers served.**

Indicator: Children/Adolescents with Mental Illness Who Also Abuse Substances to be Served in SFY'95

Surveys of adolescents in residential programs have shown that 70% have had active substance use problems. Providers have been asked to carefully review the manner in which treatment for substance abuse is addressed in their programs and to provide appropriate interventions. It is estimated that the following number of child/adolescent consumers will be served:

Area	Resid/PSUD
Metro Boston	31
North East	49
Southeastern	28
Metro West	15
Metro South	9
Central Mass.	34
Western Mass.	61
Total	**227**

DMH expects to be able to serve 227 children and adolescents with co-occurring substance use disorders through (certified "rehab option") residential services in SFY'95 based on current staffing capacity and need.

Objective II/1e-S: Provide forensic evaluations and/or treatment for all individuals referred to DMH through the criminal justice system.

The Department is required to perform evaluations or provide treatment for all individuals referred through the criminal justice system, including determination of competency to stand trial, determination of criminal responsibility, need for hospitalization, aid in sentencing, observation and examination. Forensic services are provided to court clinics and county houses of correction and in DMH-operated inpatient facilities and DMH-contracted replacement units. The Department's forensic division maintains a data base of adults and children referred to court clinics and those admitted to inpatient facilities for evaluation and/or treatment. The data below represent the number

of evaluations performed in inpatient facilities or court clinics during the fiscal year, not the number of individuals seen. Individuals may have received more than one evaluation during the year or may have been evaluated at a court clinic and subsequently admitted to an inpatient facility.

Indicator: Forensically Involved Consumers Served in SFY'94

The following number of statutory evaluations were performed on **adults** residing in inpatient units and seen in court clinics during SFY'94 (serves as an estimate for SFY'95):

Area	Inpatient	Court Clinic
Metro Boston	250	2,449
North East	23	1,264
Southeastern	2	1,060
Metro West	9	234
Metro South	5	447
Central Mass.	10	832
Western Mass.	82	926
Total	**381**	**7,212**

The Department expects to provide forensic mental health services to all individuals referred by the courts in SFY'95. The inpatient data refer to evaluations for adults performed in CMHCs or replacement units only, and represent only **36%** of the total number performed since most inpatient evaluations take place in state hospitals.

The following number of statutory evaluations were performed on **children and adolescents** seen in court clinics during SFY'94:

Area	Court Clinic
Metro Boston	**1,242**
North East	750
Southeastern	98
Metro West	102
Metro South	296
Central Mass.	106
Western Mass.	408
Total	**3,002**

There were 36 child/adolescent inpatient evaluations performed in SFY'94 in the DMH-funded adolescent inpatient units located at Taunton and Westborough State Hospitals. These units serve adolescents across the state.

ADULT ONLY OBJECTIVES

Objective II/1f-A: Refine and expand the forensic inventory and data base.

Indicator: A report regarding DMH forensic services offered in the courts, and accurate and timely information about all patients committed under relevant forensic sections of the Massachusetts General Laws for evaluation or continuing care, is generated monthly through a contractual arrangement with the UMass Medical School's Law and Psychiatry Program. In addition, the Department will be able to identify, by court, the numbers and types of evaluations requested, and whether they pertain to adult or juvenile defendants.

Objective II/1g-A: Refine and expand secure capacity in the inpatient system.

Indicator: Continuing care capacity for forensic patients in Metro Boston will be resolved and a plan for appropriate services will be implemented; a decision regarding the need for additional beds for forensic males and females will be made; and a special Utilization Review process for these patients established.

CHILD ONLY OBJECTIVES

Objective II/1h-C: Reassess and refine, as appropriate, systems to track inpatient forensic capacity for children and adolescents as well as their inpatient status and discharge information.

Indicator: The Department develops special utilization review mechanisms for use in juvenile inpatient settings that provide services to children involved with the criminal justice system.

ADULT ONLY OBJECTIVE

Objective II/1i-A: Maintain staffing levels required to serve the same number of elderly consumers served in SFY'94.

Indicator: Elders to be Served in SFY'95.

DMH Area	Case Managed	Inpatient	Residential
Metro Boston	42	26	25
North East	62	10	16
Southeastern	160	18	38
Metro West	38	1	23
Metro South	30	2	4
Central Mass.	76	2	16
Western Mass.	76	2	93
Total	**538**	**64**	**215**

DMH expects to be able to serve 538 individuals over the age of 65 through case management, 64 through inpatient and 215 through (certified "rehab option") residential services in SFY'95, based on current staffing capacity and need. Although numbers for each service represent an unduplicated count of consumers served, there is overlap among the consumers receiving different services. For a definition of "inpatient", see above. (**Note:** DMH has two specialized elder inpatient units in its own hospitals in the Metro West and Central Mass. Areas that provide acute and continuing care inpatient services to DMH priority consumers.)

Objective II/1j-A: Continue to reduce the overall number of medically ill/mentally ill ("MI/MI") individuals residing in DMH-operated facilities.

Indicator: The percentage of MI/MIs is three percent or less of the total number of patients in DMH-operated facilities.

Management Information Systems

GOAL II/2: CONTINUE THE DEVELOPMENT PROCESS FOR THE CONSUMER REGISTRATION AND ENROLLMENT SYSTEM CONSISTENT WITH THE NEED TO PROVIDE ACCURACY OF INFORMATION WHILE PROTECTING THE PRIVACY OF ENROLLEES.

SHARED OBJECTIVES

Objective II/2a-S: Complete and publish a Request for Proposals to procure a business partnership to jointly develop the new Registration and Enrollment System (RES).

Indicator: A vendor contract to develop the system is approved.

Objective II/2b-S: Design and develop an implementation plan for the Registration and Enrollment System.

Indicator: A detailed plan on the process to test and install a functional prototype is produced.

Indicator: Approval is obtained from interested parties and the implementation approach is defined.

Objective II/2c-S: Implement Phase 1 of the RES.

Indicator: The first phase of the software as determined and approved via the prototype is developed, tested and installed.

Objective II/2d-S: Implement Phase 2 of the Communication Infrastructure.

Indicator: Connectivity to all DMH Area offices for the purpose of access to the Data-Warehouse for Generalized Reporting, email and support of the RES prototype and Release 1 is provided.

REQUIREMENT #III: The State plan shall describe available services, available treatment options, and available resources (including Federal, State and local public services and resources and to the extent practicable, private services and resources) to be provided to individuals with a serious mental illness or emotional disturbance.

One of the primary goals of the Department's Comprehensive Community Support System planning and implementation initiative has been to identify and eliminate barriers to accessible care. This has necessitated attention to adults and children with a serious mental illness or emotional disturbance as well as to special and sub-populations of individuals who are elderly, deaf or hard of hearing, dually diagnosed, homeless, members of racial or cultural/linguistic minority groups or in need of emergency or forensic mental health services. There has been extensive attention paid over the last two years to working with the Division of Medical Assistance/Medicaid (DMA) and its mental health and substance abuse provider, Mental Health Management of America, Inc. (MHMA), to integrate systems of care for our shared populations. DMH and DMA have reached an agreement to address the need for purchasing services with joint funding. The Department is also committed to ensuring that the human and legal rights of all consumers are protected, whether in DMH-operated or vendor-operated programs.

The DMH direct services budget for SFY'95 is $486.3 million, of which $54.1 million is specifically earmarked for child/ adolescent services. Naturally, program content is tailored to the age and intensity of service need of the individuals served. Categories include: inpatient; emergency services, including crisis stabilization, crisis placement and respite; day treatment; a range of residential services, including supported housing; supported employment; supported education programs; outpatient treatment; home-based support and treatment; day activity programs; therapeutic recreation; medication monitoring; psychosocial rehabilitation programs, including clubhouses; case management; legal assistance; family support; and consumer empowerment activities. The Individual Service Plan, developed for each case managed individual, serves as the linchpin to assure that the consumer has access to and receives appropriate

services from DMH and relevant community agencies in an integrated and coordinated manner. In addition, the Department remains vigilant in its commitment to protecting the human rights of consumers.

The Elder Mental Health subcommittee of the State Mental Health Planning Council initiated a program during SFY'94, which will continue through SFY'95, to provide training and education through a series of statewide conferences for DMH employees, vendors and other senior advocates, to improve and increase mental health services to the elderly. Funded through the federal block grant, this program is expected to identify the mental health needs of the older population through increased awareness of the early signs of mental illness and the need for complete evaluation and early treatment. Information will be furnished regarding available resources and a protocol established for assessing psychiatric crises in this population.

Regarding forensic mental health services, the introduction of clinical consultation by forensic specialists will continue the Department's focus on issues of risk assessment and management, including the need for training of inpatient personnel by specialists familiar with the concerns of violence and dangerousness.

The Department will continue its effort to develop (legislatively) a conditional release system that extends to forensic patients the same set of community opportunities for treatment in the least restrictive environment that are routinely enjoyed by non-forensically involved individuals. The Department also expects to complete its development of secure inpatient regulations during this fiscal year.

Key areas needing continued attention and improvement still include service integration, particularly for DMH consumers who are also Medicaid recipients, and increased access and appropriate staffing and programming for ethnic and minority populations and others requiring specialized services. DMH received a federal grant from the Administration for Children and Families in FFY'94, continued in FFY'95, to train mental health professionals in adoption related issues and to provide specialized home-based crisis intervention services to adopted children.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Increased Access to Services

GOAL III/1: COLLABORATE WITH THE DIVISION OF MEDICAL ASSISTANCE/MEDICAID (DMA) AND ITS VENDOR, MENTAL HEALTH MANAGEMENT OF AMERICA (MHMA), TO ASSURE MAXIMUM INTEGRATION AND COORDINATION OF SERVICES TO DMH PRIORITY CONSUMERS.

SHARED OBJECTIVES

Objective III/1a-S: Develop a plan with DMA to address the need for jointly purchased services.

Indicator: A plan is developed.

Objective III/1b-S: Commence statewide implementation of a standardized data collection instrument for Designated Emergency Programs in order to monitor the utilization of these services and to review the triage of cases.

Indicator: The system is implemented during the first quarter of SFY'95 and it is jointly agreed upon by DMA and DMH.

Objective III/1c-S: Continue regular meetings with DMA to address systems issues related to the development of a seamless system of care. Develop agreements, protocols or joint purchasing strategies, as needed, in order to address systemic issues if they are identified.

Indicator: Monthly meetings are held with DMA and MHMA for the purpose of addressing systems issues.

Indicator: Meetings are held every other month with DMA in order to negotiate agreements, as needed, relative to the overall development of a seamless system of care.

CHILD ONLY OBJECTIVE

Objective III/1d-C: Conduct training for DMH field staff, including case managers, about access to entitlements available under the Massachusetts Children's Medical Security Act.

Indicator: Training materials are prepared and training meetings held for field staff.

GOAL III/2: CONTRACT WITH A SUFFICIENT NUMBER OF ACUTE AND CONTINUING CARE BEDS IN PRIVATE AND GENERAL HOSPITALS TO MEET THE NEEDS OF DMH CONSUMERS.

SHARED OBJECTIVE

Objective III/2a-S: Monitor utilization patterns to determine optimal number of beds needed.

Indicator: Through a joint program, both DMH and Medicaid data regarding psychiatric hospitalization utilization patterns are monitored quarterly and used to assess the match between bed demand and utilization. Findings from this data contribute to discussions about increasing or decreasing beds. This is a central office planning activity, supplemented by documentation from each Area's CCSS planning and reviews.

CHILD ONLY OBJECTIVES

Objective III/2b-C: Continue to assess the need for continuing care inpatient beds for children and adolescents.

Indicator: Need is assessed on a regular basis through review of utilization rates, average lengths of stay and waiting lists for continuing care beds.

Objective III/2c-C: Continue to assess the numerical adequacy of acute inpatient beds provided for uninsured children and adolescents through free care arrangements with private psychiatric hospitals.

Indicator: Adequacy of inpatient resources is monitored through review of monthly reports prepared by each Area indicating the utilization of the free care beds allocated to the Area, waiting lists and number of acute care bed days purchased or borrowed if the demand for hospitalization exceeded the free care allocation.

Objective III/2d-C: Facilitate good working relationships between DMH and the hospitals providing free care.

Indicator: Meetings are held as needed with the Massachusetts Association of Psychiatric Health Systems to address issues regarding free care. Letters of understanding are developed between the DMH Areas and the private psychiatric hospitals in which they have been allocated free care beds.

Access to Services for Special and Sub-Populations

GOAL III/3: ENSURE ACCESS TO SERVICES FOR SPECIAL AND SUB-POPULATIONS.

SHARED OBJECTIVES

Objective III/3a-S: Implement SFY '95 recommendations in the CCSS plans relative to special and sub-populations.

Indicator: Compliance is monitored through the annual CCSS review process which includes annual reassessment of met needs and extensive consumer participation and comment.

Deaf and Hard of Hearing

Objective III/3b-S: Maintain current standards and access for consumers who are also deaf or hard of hearing while statewide initiatives as part of the CCSS planning process are completed.

Indicator: CCSS plans are reviewed for inclusion of adequate and appropriate planning for the needs of deaf and hard of hearing consumers.

Objective III/3c-S: Continue meetings in collaboration with Mass. Commission for the Deaf and Hard of Hearing (MCDHH) consumers and clinicians to complete needs assessment and recommendations for mental health services to meet local accessibility standards and specialty programs for the deaf and hard of hearing community.

Indicator: A steering committee co-chaired by the commissioners of DMH and MCDHH meets monthly to oversee a statewide plan for this population. A subcommittee developing a proposal for an acute service strategy reports its findings to the steering committee.

Mental Illness and Substance Abuse

Objective III/3d-S: Improve both the specificity and continuum of addiction recovery and addiction prevention services for persons with serious and persistent mental illness.

To realize this objective the Department has established the following guidelines:

- DMH is responsible for developing addiction recovery programming for those with serious and persistent mental illness within its own service system;
- DMH will collaborate with the Department of Public Health (DPH) and DMA-Medicaid to enhance the network of non-DMH sponsored services for addicted mentally ill persons;
- Interagency planning between DPH and DMH will focus on developing and piloting model services integration strategies which enhance the care of persons with mental illness who present to either system for care.

Objective III/3e-S: Establish one jointly-sponsored (DMH/DPH) regional dual diagnosis task force in each Area/Region of the state to address both adult and child/adolescent needs.

Indicator: A list of task force members is submitted to the DMH Director of Services Integration by each Area.

Objective III/3f-S: Continue to sponsor and staff, with DPH, the statewide Task Force on Dual Diagnosis.

Indicator: A copy of the monthly agenda, minutes and attendance is maintained in the DMH Central Office. The Task Force prepares an annual report of its activities for submission to the Commissioner each fiscal year.

Objective III/3g-S: Convene an interagency planning committee on dual diagnosis, including representatives from DMH, DPH, DMA and the statewide Task Force on Dual Diagnosis to evaluate and recommend interagency strategies for improving services integration to persons who are both addicted and mentally ill.

Indicator: The Interagency Planning Committee submits an annual written report of its accomplishments to the Commissioners of DMH and DPH and meets at least annually with both Commissioners to review and plan interagency activities.

Objective III/3h-S: Sponsor an annual Interagency Conference on Dual Diagnosis with DPH.

Indicator: A conference is held during SFY'95; a copy of the conference agenda and materials is available in the DMH Central Office.

Objective III/3i-S: Sponsor a conference/working meeting on housing models that are responsive to the needs of addicted mentally ill consumers. The goal of the conference is to identify model programs and strategies for developing residential continuums of care that support sobriety.

Indicator: A conference/working meeting is held during SFY'95 and a copy of the conference agenda and materials is available in the DMH Central Office.

ADULT ONLY OBJECTIVES

Objective III/3j-A: Establish an expert panel on skills-based relapse prevention technology for the mentally ill (developed

originally under federal grant #RO1-MH46335) to make recommendations about how to integrate skills-based technologies into current programs, including: acute care, case management and continuing care.

Indicator: The agenda, minutes and attendance are maintained in the DMH Central Office by the Director of Services Integration.

Indicator: The Task Force prepares a report of its recommendations to the Director of Services Integration.

Objective III/3k-A: Develop and distribute a list of current self-help groups around the state targeted to addicted individuals with mental illness.

Indicator: The list of self-help groups is published in the Winter 1995 OCER Newsletter (Office of Consumer and Ex-Patient Relations, DMH).

Objective III/3l-A: In addition to two conferences, DMH will respond to requests from DMH Areas, as requested, for technical assistance and/or education on program development for the dually diagnosed.

Indicator: Technical assistance and/or education is provided to at least two DMH Areas.

CHILD ONLY OBJECTIVE

Objective III/3m-C: Sponsor an interagency work group to evaluate substance abuse program needs for children and adolescents with serious emotional disturbance. This may be accomplished as a subcommittee of the statewide Task Force on Dual Diagnosis, or independently.

Indicator: The agenda, minutes and attendance are maintained in the DMH Central Office. The Task Force prepares a report of its recommendations to the Director of Services Integration.

Objective III/3n-C: Establish a committee to plan a conference concerning addicted, emotionally disturbed children.

Indicator: A conference plan and date are established.

Racial and Cultural Minorities/Physically Challenged

Objective III/3o-S: Assess the need for translation of written materials for adults and children, with a focus on standardized materials that can be utilized on a statewide basis.

Indicator: Written material utilized by adults, children and family members is compiled.

Indicator: A determination is made regarding which foreign languages are pertinent to DMH priority population and which materials should be translated.

Indicator: There is a funding source and budget for translations.

Objective III/3p-S: Finalize standards related to assuring cultural competence of DMH and vendor staff.

Indicator: Standards are completed and approved.

Objective III/3q-S: Work with vendors to implement Title II (Transition Plan) of the Americans with Disabilities Act (ADA) related to program and facility access.

Indicator: Technical assistance is provided. After training, vendors complete a Title II survey instrument, that reports barriers to program access by consumers and others. As surveys are completed, needs are translated into requirements and an overall plan for remedying deficits.

Objective III/3r-S: Complete review of CCSS plans to determine the adequacy of plans to meet the needs of cultural and linguistic minority groups in each CCSS (natural service area).

Indicator: Plans are reviewed. Recommendations for improvement are made to Area Directors.

Elders

ADULT ONLY OBJECTIVES

Objective III/3s-A: Continue the work of the Elder Mental Health subcommittee, including integration of the subcommittee's recommendations into the policies, procedures, regulations, etc. of DMH. Conduct follow-up assessment of DMH's progress in taking steps to implement the recommendations.

Indicator: Regular written summaries are issued by the subcommittee examining DMH's actions in implementing the recommendations.

Objective III/3t-A: Continue specialized training programs for DMH and vendor professional staff on issues involving the mental health needs of elders.

Indicator: Three professional conferences are held as planned. Each conference trains up to 100 DMH and vendor staff.

Objective III/3u-A: Continue planning for a train-the-trainer conference regarding elder mental health needs for non-professional home healthcare corporation and Councils on Aging staff.

Indicator: The training program for non-professionals is held and educates at least 20 individuals.

Objective III/3v-A: Continue to ensure that emergency services, case managers and homecare providers, as well as nursing homes and hospitals, receive consultation and training regarding mental health services for older consumers.

Indicator: Case managers, homecare providers and staff from emergency services providers are invited to attend the three training conferences noted above in **Obj. III/3t-A.**

Objective III/3w-A: Continue to offer training to nursing home and hospital staff regarding OBRA/PASARR requirements and processes.

Indicator: Nursing home and hospital staff attend OBRA/PASARR trainings.

Children and Adolescents

CHILD ONLY OBJECTIVES

Objective III/3x-C: Continue to implement the federal grant to train mental health workers concerning special issues of adopted children and their families.

Indicator: Statewide training is held for DMH providers and case managers. Videotape of a training session is produced, to be made available to mental health providers and case managers.

Objective III/3y-C: Continue to provide home-based crisis intervention services to address the special needs of adopted children with mental health problems.

Indicator: At least 20 adopted children and their families are provided with home-based crisis intervention services.

Objective III/3z-C: Increase the availability of services for sexually abusive adolescents.

Indicator: DMH, DSS and the Division of Medical Assistance (Medicaid) develop a mutually agreed upon plan for establishment of additional services for sexually abusive adolescents.

Objective III/3aa-C: Increase the knowledge of mental health providers about effective interventions for sexually abusive children and adolescents.

Indicator: Support is provided for a statewide conference on Juvenile Sex Offenders.

Forensically Involved Consumers

GOAL III/4: ENHANCE THE CLINICAL CAPACITY OF THE DEPARTMENT TO EVALUATE AND TREAT FORENSIC PATIENTS AND MAKE THE DEPARTMENT MORE RESPONSIVE TO THE NEEDS OF INDIVIDUALS WITH MENTAL ILLNESS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM.

ADULT ONLY OBJECTIVES

Objective III/4a-A: Refine the centralized clinical capacity regarding forensic inpatients, thereby providing an informed system of risk assessment and management to the DMH inpatient network.

Indicator: The forensic division of DMH reports monthly on the number of forensic evaluations performed and the length of time taken to complete the process.

Objective III/4b-A: Provide training and consultation to the DMH inpatient service system regarding civilly committed patients who present possible issues of risk to public safety.

Indicator: DMH forensic staff meet with DMH Area Directors and Chief Operating Officers of DMH facilities to determine training needs of clinical and administrative Area staff; forensic staff conduct these training sessions and maintain a log of these training activities.

Objective III/4c-A: Develop and submit legislation for a conditional release system and prepare the community mental health system for a conditional release initiative; involve consumers and advocates in the process.

Indicator: The Department submits a legislative proposal for a program of conditional release during the 1995 legislative session; the forensic division meets with Area Directors, legal advocates and consumers to discuss ways of preparing the community for such a program.

Objective III/4d-A: Develop forensic (secure) inpatient regulations.

Indicator: A draft of proposed regulations is submitted to the DMH Policy and Planning Committee for review prior to further consideration of implementation of the regulations as DMH policy.

Objective III/4e-A: Maintain DMH presence in county correctional facilities.

Indicator: Contracts with county facilities continue; the effectiveness of services provided is measured by observing a decrease in the numbers of MGL Chapter 123 section 18a commitments to DMH inpatient facilities or to Bridgewater State Hospital (a Department of Corrections facility).

CHILD ONLY OBJECTIVES

Objective III/4f-C: Use DMH forensic consultants (child-trained) to conduct inpatient evaluations for children and adolescents.

Indicator: A newly developed, more focused set of guidelines identifying children appropriate for clinical review enables these forensic specialists to concentrate on juvenile inpatients most in need of assessment; a data base developed and maintained by the forensic division documents that decisions regarding privileges or discharge, as a result of completed assessments, are made on a timely basis.

Objective III/4g-C: Continue to promote appropriate discharge planning for children and adolescents involved with the criminal justice system

Indicator: Risk assessments are conducted for individuals in inpatient units and Intensive Residential Treatment Programs as part of discharge planning.

Objective III/4h-C: Continue to seek effective interventions for children and adolescents not responding to their current treatment plans.

Indicator: Consultation is provided to staff of inpatient units and IRTPs regarding different treatment approaches.

Protection and Advocacy

GOAL III/5: ENSURE THAT CONSUMERS ARE AWARE OF AND AFFORDED THEIR HUMAN AND LEGAL RIGHTS, INCLUDING ACCESS TO LEGAL ADVOCACY SERVICES, IN ALL FACILITIES AND PROGRAMS OPERATED OR FUNDED BY THE DEPARTMENT.

Through provision of regular training for human rights officers and human rights committees, two annual human rights conferences for DMH and vendor employees, consumers, family members and other advocates, and distribution of a handbook concerning the human and legal rights of consumers, implement the following objectives:

SHARED OBJECTIVES

Objective III/5a-S: Ensure that consumers and legal guardians are aware of and afforded their human and legal rights in all facilities and programs operated or funded by DMH, including contracted community service programs and privatized acute replacement units.

Objective III/5b-S: Ensure that consumers and legal guardians in community -based programs are aware of their right to file a complaint under the Department's regulations (104 CMR 24.00) and that consumers and legal guardians in acute replacement units are aware of their right to file a complaint as provided for in the contract.

Indicator: Two statewide trainings are provided for human rights officers and human rights committee members explaining the human and legal rights of consumers and how to train consumers regarding their rights.

Indicator: A comprehensive human rights handbook is distributed that describes consumers' rights in community and inpatient facilities, including the right to file a complaint under 104 CMR 24.

Indicator: Technical assistance is provided to human rights officers and additional human rights trainings are provided as necessary for staff, consumers, human rights officers and others.

Indicator: A mechanism is established to monitor the complaint process at acute replacement units.

Objective III/5c-S: Ensure that consumers are aware of the availability of assistance from independent legal advocacy programs, including the Center for Public Representation's Protection and Advocacy Program for Individuals with Mental Illness and the Mental Health Legal Advisors Committee.

Indicator: Two statewide trainings are provided for human rights officers and human rights committee members explaining the human and legal rights of consumers and how to inform consumers regarding the availability of legal advocacy programs, including the Center for Public Representation's Protection and Advocacy Program for Individuals with Mental Illness and the Mental health Legal Advisors Committee.

Indicator: A human rights handbook is distributed that describes the availability of (and how to contact) the legal advocacy programs.

Objective III/5d-S: Continue to support independent citizen monitoring activities in all facilities and programs operated or funded by the Department.

Indicator: Plans are developed by Area Offices that integrate citizen monitoring oversight into Area Board responsibilities.

GOAL III/6: CONTINUE TO IMPLEMENT STRUCTURAL CHANGES IN THE OFFICE OF INTERNAL AFFAIRS (OIA) THAT PROTECT THE LEGAL AND HUMAN RIGHTS OF CONSUMERS AND ENSURE ACCOUNTABILITY ON THE PART OF DMH.

SHARED OBJECTIVE

Objective III/6a-S: Formalize and standardize complaint intake, screening and investigation assignment procedures in all Areas.

Indicator: Department-wide meetings are held and specific practices addressing these issues are adopted.

Objective III/6b-S: Provide training to Area personnel in complaint/investigation processes and critical incident reporting.

Indicator: Trainings are provided.

Objective III/6c-S: Establish formal liaisons and referral processes with office of the Attorney General of the Commonwealth for purposes of criminal prosecution of abuse cases.

Indicator: A proposal is submitted to the Attorney General and EOHHS for such referral processes.

Objective III/6d-S: Develop the Office of Internal Affairs' capacity for investigating complaints from a clinical perspective.

Indicator: The authorized number of clinical positions within OIA are filled.

Objective III/6e-S: Expand the data processing capability of OIA outstationed personnel.

Indicator: Personnel receive the necessary hardware and software and training in use of same.

ADULT ONLY OBJECTIVE

Objective III/6f-A: Further improve usefulness of Office of Internal Affairs data base in terms of analysis and trend evaluation by including, for purposes of context and comparison, available client census (by service type and Area). Work with DMH Applied Information Technology division to accomplish this task.

Indicator: Data are available to OIA on a regular basis and are included in regularly issued OIA data reports.

REQUIREMENT #IV: The State plan shall describe health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to adults and children with serious mental illness or emotional disturbance with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Department's initial Comprehensive Community Support System (CCSS) planning process focused on identifying the array of services in each Area, including other state agency, generic and community support services available to all citizens, and the need to reconfigure DMH resources and leverage non-DMH dollars to ensure that local services meet the needs and preferences of consumers. The initial plans were reviewed to uncover gaps in services and corrective action plans were submitted for review in all of the DMH Areas except Metro Boston, which is on a later timetable. In SFY'95, steps will be taken and, where possible, resources reconfigured, to implement the recommendations, although it should be clearly noted that this process is expected to span more than one fiscal year. The charts immediately following this narrative describe the array of contracted community programs and both contracted and state-operated inpatient services provided to DMH priority consumers. Measurements are expressed as **capacity indicators** because, as explained earlier in this document, DMH will not be able to accurately measure specific numbers of consumers served in community programs until the new Registration and Enrollment System is completed. The Department will continue, in SFY'95, to develop additional non-institutional residential capacity as well as other community support services, such as supported education and employment, emergency and planned respite, clubhouses and family support services that enable consumers to live independently in communities of their choice. During SFY'94, significant funding made available as a result of the closure of the Gaebler Children's Center was allocated for the development of community-based services for children under age 14 to address significant gaps in community programming for this age group. This focus on younger children remains a priority. In SFY'95, DMH will continue its active involvement in "Roxbury Unites for Families and Children," a mental health initiative in the Metro Boston Area funded by the Annie E. Casey Foundation for which DMH is the lead agency, as well as with two other interagency initiatives. DMH also recognizes the need for comprehensive planning for transitional services for older adolescents aged 17-22 who often lose their entitlement to many services during those years.

Commonwealth of Massachusetts

Adult Mental Health Services

Contracted Community Programs[1] & DMH-Operated or Funded Inpatient Beds

Annual Capacity, State Fiscal Year 1995

SERVICE TYPE	CAPACITY INDICATOR	DMH AREA							STATE-WIDE	TOTALS
		WM	CM	NE	SE	MS	MW	MB		
A. Emergency Services										
Designated Emergency Program[2]	As Needed	AN	AN	AN	AN	AN	AN	AN	AN	As Needed
B. Skill Development. & Employment[3]										
Skills Training	Days	20,570	15,715	33,282	30,739	8,389	11,650	19,800	1,000	141,145
Clubhouse	Hours	224,597	170,939	139,620	473,228	193,000	288,704	313,373	0	1,803,461
Supported Employment	Days	17,440	4,439	6,750	7,500	18,500	3,250	6,988	0	64,867
C. Residential Services										
Specialized	Bed Days	9,855	0	1,095	365	1,460	0	730	0	13,505
High Intensity	Bed Days	6,935	21,900	29,930	42,541	15,695	17,520	22,630	0	157,151
Moderate Intensity	Bed Days	730	53,290	50,735	73,002	2,920	730	106,215	0	287,622
Low Intensity	Bed Days	18,250	10,950	85,410	33,945	0	4,014	68,143	0	220,712
Satellite	Bed Days	167,534	0	48,545	17,155	60,955	93,075	121,281	0	508,545
Supported	Bed Days	49,699	89,132	14,040	26,993	42,381	36,578	266,905	0	525,728
D. Clinical Services[3]										
Psychiatric Day Treatment	Days	18,168	0	6,136	3,735	3,535	7,281	5,723	0	44,578
Outpatient	Hours	40,750	11,254	15,022	11,390	0	3,693	22,012	0	104,121
E. Support Services[3]										
Drop-in	Hours	14,739	0	18,811	5,326	1,329	0	127,946	0	168,151
Client/Family Support	Hours	9,984	0	0	683	0	0	12,698	20,570	43,935
Community Support	Hours	101,916	33,111	33,480	14,418	38,100	35,970	156,861	2,838	416,694
Individual Support[4]	Variable	Variable	Variable	Variable	Variable	Variable	Variable	Variable	Variable	Variable
F. State-operated Inpatient										
Hospital	Bed Days									320,105
CMHC	Bed Days									96,725
G. State-purchased Inpatient										
Acute	Bed Days									64,605
Continuing Care	Bed Days									63,510

FINAL VERSION, SFY 1995 BLOCK GRANT (9/29/94): BG95ADLT.SAM

[1] Does not include capacity of DMH-operated Community Programs

[2] DEP's maintain continuous availability 24 hours a day, seven days a week and respond to demand.

[3] Metro-Boston's actual capacity in these categories may vary from that reported here because some of the Area's programs are being rebid mid-fiscal year. Figures provided are estimates, derived from annualizing current contracts.

[4] Flexible program designed to provide individually tailored supports and, as such, capacity varies depending on the types and duration of supports provided.

Commonwealth of Massachusetts

Child/Adolescent Mental Health Services

Contracted Community Programs[1] & DMH-Operated or Funded Inpatient Beds

Annual Capacity, State Fiscal Year 1995

SERVICE TYPE	CAPACITY INDICATOR	DMH AREA							STATE-WIDE	TOTALS
		WM	CM	NE	SE	MS	MW	MB		
A. Emergency Services										
Crisis Placement	Bed days	3,106	2,190	4,380	2,511	730	1,416	3,321	0	17,654
Designated Emergency Program[2]	As Needed	AN	AN	AN	AN	AN	AN	AN	AN	As Needed
B. Non-residential Services										
Home Based Services	Hours	23,028	39,380	1,400	27,868	22,250	6,420	16,354	6,760	143,460
Day Treatment 1	Days	7,667	410	169	0	0	8,620	4,480	0	21,346
Day Treatment 2	Days	3,372	0	2,700	17,279	0	2,488	0	0	25,839
Flexible Support[3]	Variable	Variable	Variable	Variable	Variable	Variable	Variable	Variable	Variable	Variable
Out Patient Services	Hours	20,697	3,381	2,870	3,823	0	0	6,348	0	37,119
Community & School Therapy[4]	Hours	10,381	5,951		12,174	0	0	63,026	0	91,532
C. Residential Services										
Therapeutic Family Care	Bed Days	5,110	620		1,460	0	2,068	0	0	9,258
Residential I	Bed Days	8,760	4,380	9,125	2,190	0	5,110	3,285	10	32,860
Residential II	Bed Days	7,300	5,110	7,209	2,190	0	5,475	5,110	0	32,394
Residential III	Bed Days	730	0	3,285	0	0	4,379	0	0	8,394
Flexible Support	Bed Days	0	365	0	365	4,462	730	1,095	746	7,763
Intensive Residential	Bed Days	4,380	0	0	0	0	0	0	70	4,450
D. Inpatient Services										
Adolescent Continuing Care	Bed Days									16,425
Latency Age Continuing Care	Bed Days									5,840

FINAL VERSION, SFY1995 BLOCK GRANT (9/29/95): BG95_KID.SAM

[1] Does not include capacity of DMH-operated Community Programs

[2] DEP's maintain continuous availability 24 hours a day, seven days a week and respond to demand.

[3] Flexible program designed to provide individually tailore supports and, as such, capacity varies depending on the types and duration of supports provided.

[4] Metro-Boston's actual capacity in Community and School Therapy may vary from that reported here because this program is being rebid mid-fiscal year.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/ Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Extent and Availability of Services

GOAL IV/1: PLAN FOR, DEVELOP, MAINTAIN OR CREATE LINKAGE AMONG A SUFFICIENT NUMBER AND ARRAY OF SERVICES TO ENABLE CONSUMERS TO REMAIN IN THE COMMUNITY IN THE LEAST RESTRICTIVE AND MOST NORMALIZED SETTINGS.

SHARED OBJECTIVES

Objective IV/1a-S: Assure that final multi-year CCSS plans address the need for an integrated service system that includes health, rehabilitation, employment,residential and educational services and other community supports.

Indicator: The CCSS review process documents deficiencies, specifies corrective action plans and monitors compliance.

Objective IV/1b-S: Work with Medicaid and its vendor, MHMA, to ensure that DMH adult and child consumers, no matter who is the payer, are receiving intensive clinical support in the community in order to reduce their utilization of high cost inpatient care.

Indicator: Regional meetings are conducted between Area Directors and MHMA Regional Managers to identify the DMH/MHMA consumers who have a history of repeat hospitalizations or excessive use of inpatient care. The specific services purchased by MHMA in accordance with their Intensive Clinical Management initiative are defined, in order to address the specific needs of those consumers and to meet the needs defined in the CCSS plans.

Indicator: The Intensive Clinical Management initiative is implemented.

Objective IV/1c-S: Assess current methods for gaining access to generic employment and training services in order to promote the development of employment opportunities for mental health consumers. Determine best practices for the role of DMH and its providers in supporting consumers to succeed in reaching their employment and training goals.

Indicator: Employment coordinators are established in each of the Area Offices.

Indicator: Meetings are convened in each Area between the Area Director and his/her counterpart at the state Division of Employment and Training (DET) in order to facilitate communication and pursue options for the development of joint initiatives.

ADULT ONLY INDICATOR

Indicator: A pilot program is established in the Metro Boston Area during SFY'95 between DMH and DET.

ADULT ONLY OBJECTIVES

Objective IV/1d-A: Develop new housing units with local housing authorities, using funds from the state's Chapter 689 program, generic affordable housing resources (e.g., federal and state rental certificates) and from resources targeted for the homeless mentally ill (HMI).

Indicator: 100 new units are developed. (The actual number of units for the HMI is dependent on funding through several pending federal applications for McKinney funds. Approximately $7 million appropriated by the SFY'95 state budget for this purpose will be used to leverage federal funds.)

Objective IV/1e-A: Maintain funding for and access to atypical neuroleptic medications, for all consumers who meet the clinical criteria, enabling them to function independently in the community rather than in long-term hospital or other similarly restrictive settings.

Indicator: The Deputy Commissioner for Clinical and Professional Services receives quarterly reports that monitor the number of patients, statewide, who receive atypical neuroleptics.

Objective IV/1f-A: Conduct a pilot study on outcome measures for consumers with serious mental illness. The methods of measuring outcomes should be applicable to all DMH consumers on a regular and routine basis, and should include health status, quality of life and satisfaction with services.

Indicator: A pilot study is completed.

Objective IV/1g-A: Continue implementation of the federal grant in the Central Mass. Area through a collaboration including the Mass. Rehabilitation Commission, DMH Area office, DMH-funded clubhouse (Genesis), a local CMHC day program and a local college to provide advanced employment opportunities for people with mental illness.

Indicator: Twenty-five to 30 consumers are placed.

New Service Programs

GOAL IV/2: COLLABORATE WITH OTHER PUBLIC AND PRIVATE AGENCIES TO COORDINATE AND IMPROVE DELIVERY OF SERVICES TO DMH CONSUMERS.

CHILD ONLY OBJECTIVES

Objective IV/2a-C: Support ongoing local efforts focusing on interagency collaboration and use of wraparound funds to enable children to remain in their own homes and communities.

Indicator: Funding is maintained for the Northeast Area's Lynn Project, initially established under CASSP, and for Project Connect in the DMH Metro South Area.

Objective IV/2b-C: Promote delivery of appropriate services for children with mental health problems whose parents are seeking voluntary out-of-home placement from the Department of Social Services.

Indicator: The EOHHS Interim Policy, under which these children are referred to DMH for assessment and linkage to appropriate resources, continues to be implemented, subject to modification through interagency agreement.

Objective IV/2c-C: Promote appropriate service delivery, by assuring that children and their families seeking services from DMH and/or DSS receive comprehensive assessments that look at both clinical mental health need and family circumstances.

Indicator: A plan is developed by DMA, DSS and DMH for the common intake, assessment and triage of children with mental health problems.

Objective IV/2d-C: Assure appropriate use of residential treatment for children served through DMH and DSS.

Indicator: A plan is developed by DSS, DMH and DMH for a common system for utilization management of residential placements.

Objective IV/2e-C: Facilitate children's access to special education services.

Indicator: A video on strategies for gaining access to special education entitlements is distributed to DMH field staff and case managers.

Objective IV/2f-C: Facilitate appropriate transition to post-secondary school life for children with mental health needs.

Indicator: A meeting between DMH and Department of Education staff is held to identify strategies to increase mental health provider's and parent's awareness of transitional planning requirements under IDEA (federal special education law).

REQUIREMENT #V: The State plan shall describe the financial resources and staffing necessary to implement the requirements of such plan; including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.

The 1995 State Plan reflects realistic objectives that are achievable within the SFY'95 state appropriation of $505.6 million (includes $54.1 million for child-specific services), plus funds derived from the federal block grant and other federal, private and public dollars. Of the total state appropriation, $8.5 million is projected for child/adolescent inpatient services (all contracted programs) and $177.6 million is projected for adult inpatient services (in state hospitals, state-operated community mental health centers (CMHCs) and acute and continuing care replacement units in general and private hospitals). The remaining dollars are dedicated to other community-based services and administrative support. The SFY'95 budget includes some expansion of mental health services but the legislature rejected the Department's request for an Area-based account structure, opting instead for DMH centrally controlled mega-accounts for Administration, Adult Community Services, Child and Adolescent Services, Forensic Services and State Hospitals.

Since 1988, DMH has significantly increased the amount of revenue it generates from its state hospitals, CMHCs and Intensive Residential Treatment

Programs (IRTPs), as well as from the Medicaid Rehab Option and case management services for DMH Medicaid-eligible consumers ($8.7 million in SFY'88, $69.6 million in SFY'94). The Department further increased generated revenue through third party reimbursement garnered by contracted replacement units in general, private and municipal hospitals. With the exception of revenue from the CMHCs, which is retained by DMH in statutorily created trust funds under the Department's control, and a small ($125,000) retained revenue account for occupancy fees from CHOICE housing, all other revenue goes to the General Fund (state treasury). However, since the Department's final state appropriation is evaluated by the legislature on a net state cost basis, revenue generation is a significant factor in supporting the Department's budget and Public Managed Care initiative.

DMH consumers receive services from both state-operated and vendored programs. The majority of state-operated programs provide continuing inpatient care in state facilities, although inpatient care accounts for less than half of the DMH budget. Currently, the Department employs 4,857 FTEs and has 819 program contracts with providers (614 are adult only or generic adult/child services and 205 are child-specific). The Department believes the 1995 State Plan objectives can be achieved with the existing combination of state and provider staff with the realization that in order to use existing resources efficiently and effectively, both DMH and its providers must adhere to the Department's utilization management standards (specific goals and objectives related to Utilization Management are found under Requirement VI). As important, is the need to work continuously to increase the availability of qualified culturally diverse staff and to develop and refine the policies and procedures necessary to implement the Americans with Disabilities Act of 1990. Finally, DMH has an active agenda in SFY'95 to provide training to state and vendor staff to share the knowledge and enhance the skills necessary to implement the Public Managed Care initiative.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Funds Available for Community Programs

GOAL V/1: DEVELOP AND IMPLEMENT FISCAL POLICIES THAT SUPPORT PUBLIC MANAGED CARE INITIATIVE GOALS.

SHARED OBJECTIVES

Objective V/1a-S: Generate $12 million in revenue from case management.

Objective V/1b-S: Generate $9.82 million in revenue from replacement units (including child).

ADULT ONLY OBJECTIVES

Objective V/1c-A: Generate $6.36 million in revenue from state hospitals.

Objective V/1d-A: Generate $17.32 million in revenue from Rehab Option.

Objective V/1e-A: Generate $11.8 million in revenue from CMHCs.

CHILD ONLY OBJECTIVES

Objective V/1f-C: Generate $1.0 million in revenue from Intensive Residential Treatment Programs.

Objective V/1g-C: Generate $4.88 million in revenue from the adolescent inpatient units.

Objective V/1h-C: Generate $1.0 million in revenue from Rehab Option.

Indicator for Objectives V/1a-1h: SFY'95 Revenue Report.

Availability of Human Resources

GOAL V/2: DEVELOP AND IMPLEMENT POLICIES RELATED TO EMPLOYMENT, STAFF DEVELOPMENT AND STAFF DIVERSITY THAT SUPPORT PUBLIC MANAGED CARE INITIATIVE GOALS, ENSURE ACCOUNTABILITY THROUGHOUT THE DMH SERVICE SYSTEM AND RESPECT AND PROTECT THE RIGHTS OF CONSUMERS.

SHARED OBJECTIVES

Objective V/2a-S: Institutionalize the management merit pay program; complete SFY'94 performance reviews and initiate SFY'95 goal-setting among all agency managers.

Indicator: Performance review for all agency managers is completed and performance ratings are reflected on PMIS (Personnel Management Information System) by December 1, 1994. SFY'95 goals are established and recorded for each manager.

Objective V/2b-S: Continue implementation of a performance review program for all DMH bargaining unit employees that links job performance to merit-based adjustments.

Indicator: EPRS (Employee Performance Review System) review is completed for all bargaining unit staff. EPRS evaluations for MNA (Massachusetts Nurses Association) staff are completed by November 1, 1994 to ensure timeliness of negotiated merit-based salary adjustment. In conjunction with the Commonwealth's Office of Employee Relations, merit-based salary adjustments are negotiated with each DMH union.

Objective V/2c-S: Implement final recommendations of the DMH Evaluation Team for all field and Central Office managerial positions.

Indicator: Final implementation negotiations with the Department of Personnel Administration are completed and necessary classification adjustments are implemented.

Objective V/2d-S: Complete training of managerial staff in cultural diversity through a series of training classes and seminars that address the needs of four major cultural/ethnic groups.

Indicator: Training sessions are conducted; records are maintained.

Indicator: A roster of the number of managers who receive training in cultural competence is maintained, including an assessment of training received.

Objective V/2e-S: Maintain or attain the goal of minority representation in managerial and professional level positions utilizing the state Office of Affirmative Action 12% standard.

Indicator: Work force analysis reports are examined monthly to determine status and a comparison of overall Departmental standing is made at the start of the fiscal year and at the year's end.

Objective V/2f-S: Maintain or increase the Minority Business Enterprise participation in providing goods and services for the care and treatment of consumers, utilizing the 5% level as the standard.

Indicator: Participation is determined at the beginning of the fiscal year and quarterly status evaluations are made. Evaluation outcomes are compared at fiscal year end.

Training

GOAL V/3: DEVELOP AND ENHANCE THE KNOWLEDGE BASE AND SKILL LEVEL OF HEALTH CARE PROFESSIONALS DELIVERING SERVICES TO DMH PRIORITY CONSUMERS.

a) Use training initiatives to improve the quality of care in all program components of the Comprehensive Community Support System.

b) Ensure that all state and provider employees maintain the highest standards of care, that there is consistency of these standards statewide and that the standards of care include the most recent advances in the field.

SHARED OBJECTIVES

Objective V/3a-S: Continue to provide all DMH state and provider employees with clinical support services through the DMH Speaker's Bureau, Difficult-to-Treat Case Conferences and specialized conferences on topics such as: update on schizophrenia, psychopharmacology, quality and utilization management.

Indicator: Activities of the Speaker's Bureau, Case and Specialized Conferences are reported at least semi-annually.

Objective V/3b-S: Assist state and provider programs in addressing issues related to the DMH Policy #94-2 (HIV/AIDS) and issues related to the control of HIV and Blood-borne Pathogens, and offer consultation regarding individual cases.

Indicator: Two 3-day HIV/AIDS Train-the Trainer sessions, two 2-day programs on HIV/OSHA and four networking meetings are offered to state and provider programs.

Objective V/3c-S: Continue distributing HIV Prevention and Risk Reduction Part 2 videotape, instructing consumers in the development and maintenance of a drop-in educational program for people with serious mental illness.

Indicator: Videotape is distributed to each DMH Area to the HIV/AIDS Area Designated Individual; and shown twice during year as part of Policy #94-2 implementation.

Objective V/3d-S: Train all DMH state employees in the single DMH system of nonviolent self-defense. Train new hires immediately. Retrain current employees at their annual review. Make the DMH program available to any provider requesting a copy.

Indicator: Training occurs and is documented.

ADULT ONLY OBJECTIVES

Objective V/3e-A: Hold Train-the-Trainer days for the topics of psychosocial rehabilitation, multicultural issues and human rights. Continue initiatives to teach the core curriculum to every state and provider employee.

Indicator: Training occurs and is documented.

Objective V/3f-A: Decentralize adult services training to increase responsiveness to local needs.

Indicator: Trainings take place in the local service areas and are documented.

Objective V/3g-A: Continue training residential house staff to administer medication in the residences.

Indicator: Training occurs and is documented.

CHILD ONLY OBJECTIVES

Objective V/3h-C: Begin development of materials and teach child core curriculum to child/adolescent provider staff.

Indicator: Training materials are developed for at least one high priority topic.

Indicator: Initial training for DMH field staff and providers is held.

Objective V/3i-C: Continue to sponsor annual training for providers of inpatient and IRTP services.

Indicator: Training is held for inpatient and IRTP providers.

Objective V/3j-C: Continue to collaborate with New England Council of Child and Adolescent Psychiatry (NECCAP) in developing trainings on new treatment approaches for children.

Indicator: At least one training is organized for members of NECCAP.

Objective V/3k-C: Sponsor at least one training for child and adolescent service providers across the continuum of care to address issues of system integration, family involvement and resource utilization.

Indicator: Training is held on system of care for children and adolescents.

Objective V/3l-C: Sponsor a conference for child mental health professionals on treatment of foster and adopted children with severe emotional problems.

Indicator: Conference is held.

Emergency Services Training

SHARED OBJECTIVE

Objective V/3m-S: Continue emergency services training for shelter staff agency heads and community organizations. Focus special efforts on working with police.

Indicator: At least three trainings are held in different areas of the state.

Objective V/3n-S: Recruit and train new crisis counselors, as needed; continue to provide training, statewide, to ensure that trained crisis counselors are available during a designated state or federal emergency, as developed under the FEMA/NIMH crisis counseling grant.

Indicator: Area-based trainings for crisis counselors are completed for all DMH Areas. DMH participates in training exercises held by the Massachusetts Emergency Management Agency and other statewide, non-mental health agencies.

Objective V/3o-S: Ensure that all Emergency Response and Crisis Counseling plans are developed per DMH Policy #92-2.

Indicator: Each Area's plan is reviewed and approved.

Objective V/3p-S: Develop additional exercises for improving readiness for meeting the mental health needs of consumers, survivors and first responders during a federal or state emergency.

Indicator: Additional exercises are developed and implemented.

GOAL V/4: TARGET TECHNICAL ASSISTANCE AND CONSULTATION AT IMPROVING QUALITY MANAGEMENT PRACTICES.

Objective V/4a-S: Continue to provide training on quality improvement approaches and methods for Area Office quality management staff.

Indicator: Monthly meetings are held with quality management staff from the Area Offices to provide technical assistance and consultation on quality management practices.

REQUIREMENT #VI: The State plan shall provide for activities to reduce the rate of hospitalization of individuals with a serious mental illness or emotional disturbance.

Although state hospitals once comprised the primary treatment option for those with serious mental illness, they are now only one component of an array of service alternatives. Since 1992, the Department has closed three adult hospitals and the Gaebler Children's Center, the only state hospital for children. Savings derived from closing these facilities enabled DMH to transfer more than $65 million to fund an array of community-based services, including respite, crisis, residential and home-based services that have reduced both the rate of hospitalization and length of stay. During the same period, the Division of Medical Assistance (DMA) obtained a federal waiver to enroll most Medicaid recipients in a managed care program, including a carve-out for mental health and substance abuse services (MH/SA). The MH/SA program is managed for DMA by a for-profit vendor, Mental Health Management of America, Inc. (MHMA). The Department has worked actively with DMA and its vendor, MHMA, to foster an integrated system of care for shared consumers (children, adolescents and adults who receive services through DMH and DMA), including joint contracting with emergency screening teams, jointly developed protocols for admission, discharge and transfer (for adults and children) and the increasing use of diversion programs to reduce the need for hospitalization.

Adults currently receive **acute** inpatient care in seven DMH operated community mental health centers (CMHCs), eight contracted replacement units in general and private psychiatric hospitals, and in MHMA network beds across the state. **Continuing** care is provided in three of the CMHCs, one contracted municipal hospital, a public health hospital and in the four remaining state hospitals.

DMH is no longer the primary provider of acute inpatient services for children and adolescents. Children and adolescents who are Medicaid recipients receive **acute** inpatient care through MHMA network hospitals. Uninsured children receive acute inpatient care either in general hospitals or in private psychiatric facilities through free care arrangements and through a limited amount of purchased bed space. **Continuing** care is provided in three DMH-contracted adolescent units and the Gaebler replacement pediatric unit at a private psychiatric hospital.

The number of state hospital admissions, including forensic admissions, for adults (19+) per 100,000 population in SFY'94 was 23.78 (26.8 in SFY'93). This statistic is not relevant for children as the Gaebler Children's Center closed in September 1992. The total number of days of hospitalization in state hospitals for adults per 100,000 population in SFY'94 was 6,136 (6,097 in SFY'93). Again, this statistic is irrelevant for children.

DMH has achieved a reduction in the rate of hospitalization for individuals with serious mental illness through improved systems for screening, admission, utilization management and discharge planning, as well as increased development of community alternatives such as crisis stabilization and respite beds, and service integration among all CCSS components. The Department has adjusted the number of beds available in its inpatient system, in order to provide DMH consumers with access to inpatient care when necessary. The total number of adult beds available in the DMH system in SFY'95 is: 877 state hospital beds (down from 1,111 in SFY'93), 265 CMHC beds (down from 381 in SFY'93), 177 acute replacement beds and 174 continuing care replacement beds. The total number of child/adolescent beds available in the DMH system in SFY'95 is 61.

The emphasis on services integration in the CCSS plans, plus implementation of a state of the art utilization management program and tracking system developed by DMH for DMH-operated and funded inpatient sites, will continue to ensure that resources are used efficiently and inpatient care is used only when other, less restrictive forms of intervention are not appropriate, assisting patients to return to their communities, with necessary support services, as soon as possible.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Consumers in Hospitals

GOAL VI/1: ASSURE THE AVAILABILITY OF AN APPROPRIATE NUMBER OF CRISIS PLACEMENT AND RESPITE CARE BEDS TO SERVE CHILDREN IN CRISIS OUTSIDE OF INPATIENT SETTINGS.

CHILD ONLY OBJECTIVE

Objective VI/1a-C: Establish additional crisis placement/respite capacity in accordance with Area needs as identified in CCSS plans.

Indicator: Capacity is added in the DMH Northeast Area.

Programmatic Initiatives to Reduce Hospitalization

GOAL VI/2: ESTABLISH AN ORGANIZATION-WIDE UTILIZATION MANAGEMENT (UM) PROGRAM.

SHARED OBJECTIVES

Objective VI/2a-S: Provide training and technical assistance/ consultation for each Area to educate key staff about the Department's UM initiative and to engage them in the implementation of the UM program and standards.

Indicator: A formal UM training is held in each of the Areas.

Indicator: Monthly meetings are held with the UM project managers responsible for implementing the UM program at the Area level.

Objective VI/2b-S: Provide technical assistance to Areas to develop Area UM Plans. Each plan will demonstrate how the UM standards are to be operationalized in the Area.

Indicator: Area UM plans are completed that meet the above objective.

Objective VI/2c-S: Review hospital length of stay and admission rates quarterly, to set goals for DMH capacity.

Indicator: The DMH Quality Council meets quarterly to address UM issues.

Objective VI/2d-S: Develop statewide clinical criteria for day treatment, partial hospital and outpatient programs.

Indicator: Clinical criteria for the above community programs are approved by the Commissioner.

Objective VI/2e-S: Standardize UM data collection and analysis methods in collaboration with the DMH Applied Information Technologies division.

Indicator: Standardized statewide UM report are produced quarterly, commencing July 1994.

Objective VI/2f-S: Continue to merge data bases from DMA and DMH regarding services utilization, in conformance with client confidentiality regulations. The data bases will include community services as well as inpatient services.

Indicator: At least four research reports are produced analyzing the merged data.

Indicator: The existing quarterly inpatient Utilization Management Report is revised to include data from the DMA/MHMA network hospitals in addition to DMH- operated and funded inpatient units.

Objective VI/2g-S: Monitor interface with DMH and DMA in providing integrated systems of care for shared consumers (DMH and Medicaid eligible). Utilization trends and patterns relative to the interagency interaction in caring for shared consumers will be monitored. UM reports are used to identify systemic problems and inefficiencies and assist interagency collaboration to continually improve the service system for consumers.

Indicator: UM data analysis reports based on the DMH/DMA data base are produced by DMH and shared with DMA.

Objective VI/2h-S: Integrate replacement units into the Department's UM program to support appropriate and efficient use of this resource.

Indicator: All contracts with replacement units include UM standards.

REQUIREMENT #VII: The State plan shall require the provision of case management services to each individual with a serious mental illness or emotional disturbance in the State who receives substantial amounts of public funds or services.

DMH considers the provision of case management services to adult, child and adolescent consumers as the centerpiece of its Public Managed Care initiative to assure communication and linkage between consumer and services, communication among service components and access to services. DMH currently uses an "enhanced brokerage" model of case management, with each Area modifying the model to complement its overall resource configuration. The numbers of consumers receiving these services has steadily increased although DMH has not developed or approved new case management service targets pending final approval of a new model design. In addition, plans are being developed through the Executive Office of Health and Human Services (EOHHS) to create a more unified case management system for children served by child-serving state agencies. The relationship between the DMH case management system and the single case management system for children will be refined as the integration of children's services evolves.

The Department has a clearly articulated eligibility policy for case management services. In summary, priority is given to the most functionally impaired, including hospitalized consumers and those in hospital diversion programs, those in DMH supported residential programs and children and adolescents receiving intensive in-home interventions. By definition, these are the consumers who receive substantial amounts of public funds or services. New cases are identified through referrals from the Designated Emergency Programs, inpatient units and through direct referrals to the Area office.

In August 1994, 7,713 adults and 1,021 children were enrolled in the DMH case management system. The waiting list for that month included 660 adults and 207 children. It should be noted, however, that these consumers generally receive other direct services from DMH even though case management services may not be immediately available. A total of 11,352 adults, children and adolescents were assigned a case manager during SFY'94.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Case Management Model

GOAL VII/1: THE GOAL OF THE CASE MANAGEMENT SYSTEM IS TO ASSURE CONTINUITY OF CARE FOR ALL CONSUMERS OF THE DEPARTMENT BY ASSURING ACCESS TO AN APPROPRIATE ARRAY OF SERVICES BASED ON THE LEVEL OF CARE REQUIRED.

SHARED OBJECTIVES

Objective VII/1a-S: Continue planning efforts to reconfigure the DMH case management system.

Indicator: Bi-monthly reports are made to Executive Staff on the status of the case management project.

Indicator: The case management model design is finalized.

Objective VII/1b-S: Develop a competency-based staff training and continuing education plan for case management.

Indicator: A report is submitted to the Commissioner regarding training requirements.

Objective VII/1c-S: Implement steps recommended in case management plan.

Indicator: The following sub-objectives are addressed in the above referenced report:

#1: Articulate principles of case management in public managed care;
#2: Define key functions of case management in public managed care;
#3: Identify model programs and innovative models to be replicated statewide, inclusive of state and vendored models;
#4: Develop a Case Management Level of Care Index (CM-LOCI) that matches the type of case management intervention to level of need;
#5: Develop a competency-based staff training and continuing education strategy for case managers that support the goals of public managed care, standardization of services and skills development of a diverse work force;
#6: Assess and, where necessary, modify regulations/statutes/ policies at the departmental and state levels to support DMH case management goals;
#7 Evaluate current and future funding models to support DMH public managed care case management objectives;
#8: Develop a management information system strategy to support case management program evaluation, billing and research;
#9: Develop statewide implementation strategy.

Size of Population Receiving Case Management Services

Objective VII/1d-S: **Provide (DMH) case management services to 7,200 adult and 750 child and adolescent DMH priority consumers in any given month.**

Indicator: The number of consumers receiving case management services in any given month is published in the DMH monthly management report.

The statewide target for adults receiving case management services in any given month continues to be 7,200. The statewide target for children and adolescents receiving case management services in any given month continues to be 750. The case management policy and model design are still undergoing review. Changes in the statewide targets will be made once that process is concluded.

GOAL VII/2: CREATE A UNIFIED CASE MANAGEMENT SYSTEM FOR CHILDREN AND ADOLESCENTS SERVED BY STATE AGENCIES.

CHILD ONLY OBJECTIVE

Objective VII/2a-C: **Develop plan, in conjunction with other agencies under the aegis of EOHHS, to operationalize the single case management plan as outlined in an interagency proposal accepted by the Secretary of EOHHS.**

Indicator: Operational plan for initial implementation of a unified case management system is submitted to the Secretary of EOHHS.

REQUIREMENT #VIII: The State plan shall provide for the establishment and implementation of a program of outreach to, and services for, individuals with a serious mental illness or emotional disturbance who are homeless.

Massachusetts operates a well-established program of outreach to individuals with mental illness who are homeless. The PATH grant will continue to fund clinical social workers across the state who provide direct care, housing advocacy and assistance as well as referrals for job training, literacy education, mental health services, substance abuse treatment and programs that provide benefits and entitlements.

Through a NIMH and McKinney Demonstration project, 118 former shelter residents were placed and continue to be followed in two housing models - independent apartments and Evolving Consumer Households. Preliminary findings indicate that 70% of those placed were still in their originally assigned housing and only 16% had returned to shelters or were living on the street. During SFY'95, a final report on this project will be issued and disseminated. Also, continuation funding from NIMH will be sought to review other residential and treatment issues raised during the project.

The Department will manage transitional residences (formerly "shelters") for homeless mentally ill (HMI) individuals in the Metro Boston Area. These programs will receive referrals from non-DMH shelters and are oriented towards stabilization and placement. Each program will continue to be affiliated with a community mental health center (CMHC) and has clinically trained staff. In SFY'95 DMH will be working to improve coordination between these transitional residences and the mainstream community mental health centers.

DMH 's Homeless Outreach Team in the Metro Boston Area will continue to identify people in need of services, and connect them with entitlements, case management and other services. DMH will also continue to provide psychiatric nurses at non-DMH Boston shelters to treat health problems and manage medication compliance.

An Interagency Action Plan for People Who Are Homeless and Mentally Ill released in April 1993 included recommendations for a comprehensive housing strategy using state, federal and local resources; a comprehensive service and support strategy; and changes/clarification in the policies and practices of all relevant agencies. DMH will continue to rely on this Action Plan in its work with the homeless. In accordance with the plan's recommendations, a series of new homeless services projects have recently begun in Metro Boston and in areas outside of Boston. A combination of housing and support services is being arranged for at least 315 HMI individuals. Most projects leverage state funds for additional federal funds. During SFY'95, DMH will be striving to finalize project elements, setting up tracking procedures and taking advantage of federal rental assistance funds awarded to the projects through contracts in 1994.

DMH expects to enter into a formal agreement with the U.S. Department of Labor- funded Massachusetts Department of Employment and Training to provide employment services to approximately 80-100 formerly homeless individuals with mental illness.

Each CCSS plan includes a preliminary strategy for meeting the needs of homeless consumers in the Area based upon the recommendations of the Interagency Action Plan and the needs of homeless children and families. DMH will be working to ensure that these preliminary strategies are finalized into Area Office Housing Plans.

DMH hopes to expand its homeless projects by seeking additional federal and state resources in SFY'95.

Recent housing development legislation allows funds originally bonded for institutional rehabilitation to be redirected for the expansion of the residential inventory. A provision of the legislation requires up to $10 million be directed to meet the housing needs of the homeless mentally ill. DMH Central Office expects to provide project-oriented technical assistance to Area Offices to develop proposals for the use of this resource in accord with local homeless strategies and Area Housing Plans.

Finally, DMH will continue a pilot project to provide on-site service coordinators at elderly/disabled housing sites to do outreach with tenants, intervene in crisis situations, and make referrals to the appropriate human service agency as necessary to prevent unnecessary evictions and homelessness. Coordinators also attempt to foster a sense of community between elderly and disabled residents, and act as the liaison between housing managers and the social service network. This work will be evaluated.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/ Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Planning

GOAL VIII/1: **WORK WITH ADVOCATES AND OTHER STATE AGENCIES TO PLAN EFFECTIVELY FOR THE NEEDS OF PEOPLE WITH MENTAL ILLNESSES WHO ARE HOMELESS.**

SHARED OBJECTIVES

Objective VIII/1a-S: **CCSS plans for each natural service area of the state have been developed. Each includes a preliminary strategy to meet the needs of HMI based on the Action Plan. DMH Central Office will be working to ensure that each of the strategies is comprehensive and viable, by consulting with Area Office housing staff and providing them with technical information.**

Indicator: Technical assistance meetings are held. DMH Central Office accepts the Areas' strategies and incorporates these strategies into Area specific Housing Plans.

ADULT ONLY OBJECTIVES

Objective VIII/1b-A: **Implement Capital Pooling legislation, passed in 1993, that provides up to $10 million to meet the housing needs of HMI and issue regulations for**

operating the programs. Hold meetings with Area office staff and with housing partners to promote the program's implementation.

Indicator: Informational packages are completed, TA meetings are documented, Area Office requests for proposals from developers are filed and projects financed through the program are documented.

Objective VIII/1c-A: **Continue to manage and refine HMI outreach, treatment and housing services projects supported with funds available through SFY'95 supplemental budget of $7M, in accordance with the Interagency Action Plan, including projects in Metro Boston and in other areas of the state. Provide sustained housing and support services to at least 315 homeless persons, in collaboration with local housing authorities, municipalities and other local groups.**

Indicator: Reports of fiscal and programmatic progress on the respective projects, and tracking and reports on the housing and services provided to the 315 targeted individuals are available.

Objective VIII/1d-A: **Create a pilot program to enable HMI consumers to access mainstream employment services and attain jobs. Collaborate with the Mass. Dept. of Employment and Training (DET) to devise this program of supports and services for consumers before, during and after the fact of job attainment.**

Indicator: There is documentation of formal agreements between DMH-DET, records of meetings held and progress reports on the pilot.

GOAL VIII/2: **INTEGRATE CONSUMERS WHO HAVE BEEN HOMELESS INTO THE GENERAL MENTAL HEALTH SYSTEM.**

ADULTS ONLY OBJECTIVE

Objective VIII/2a-A: **Ensure that all DMH homeless services projects in the Metro Boston Area, Quincy, Lower Cape Cod, Springfield, Worcester and the Northeast Area effectively offer a range of generic DMH services, through local DMH units and providers. The following services will be included: outreach,**

stabilization, medication, crisis intervention, counseling, case management, permanent and transitional housing with support services; community treatment teams; post-crisis transitional housing; staff and consumer training/planning.

Indicator: Outreach and case management records are available as well as project progress reports.

Objective VIII/2b-A: **Continue funding Services Coordinator Pilot Project ($125,000) in public and assisted housing for elderly and disabled residents in Boston, Brockton, Cambridge, Lynn and the North Shore to promote effective intervention and services delivery, foster harmonious integration between elderly and younger disabled residents and prevent unnecessary evictions and homelessness among the disabled due to tenancy problems.**

Indicator: The program is evaluated and minutes of interagency meetings on the program's conduct are available.

Indicator: Legislation is filed, co-sponsored by DMH, that strives not only to continue funding for the current five projects but attempts to expand the program to other public and assisted housing sites for the elderly and disabled.

CHILD ONLY OBJECTIVE

Objective VIII/2c-C: **Assure that seriously emotionally disturbed children in homeless shelters receive appropriate mental health services.**

Indicator: Progress toward this objective is monitored through the regular review of the implementation status of each Area's CCSS plans as they relate to homeless children and adolescents.

REQUIREMENT #IX: In the case of children with a serious emotional disturbance, the State plan-shall provide for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which system includes services provided under the Individuals with Disabilities Education Act); shall provide that the grant for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services; and shall provide for the establishment of a defined geographic area for the provision of the services of such system.

Massachusetts does not have a single state agency that encompasses all services for children. Services for children are divided among agencies according to agency function. The key child-serving agencies include the Departments of Social Services and Youth Services that serve only children, and the Departments of Public Health, Mental Health, Mental Retardation, Public Welfare, the Commission for the Blind and the Department of Education. All except Education are part of the Executive Office of Health and Human Services (EOHHS).

The state has made a major commitment to improving care for children who require the services of more than one state agency. At the local level, the state continues to fund and support interagency coordination in program planning, service planning and service delivery. However, in recognition of the fact that these local efforts often face impediments created by state policies, regulations and agency administrative structures, the Executive Office of Health and Human Services has created a Children's Service Integration Committee, composed of key managers of the seven key EOHHS child-serving agencies, which meets weekly. The committee has developed a multi-year plan that will create a seamless system of care for families at the service level, and clarify the administrative, fiscal and service responsibilities of the child-serving agencies. The goal is to establish the necessary structures to enable all children and families, regardless of the complexity of their needs, to have access to the full array of state services available to promote their development. The work of the committee is to direct the ongoing implementation of the plan.

For several years, Massachusetts has had a funding mechanism, "Chapter 688" (Turning 22 law) to continue services for individuals who were too old to be eligible for special education, and where appropriate services were not available through existing programs. Chapter 688 required preplanning two years before the termination of special education eligibility. The passage of the federal Individuals with Disabilities Education Act, which calls for transitional planning to begin at age 14, has significantly increased the attention being paid by all state agencies to preparing these adolescents and young adults for

independent living, employment opportunities and ongoing education. Within the DMH system, each Area is responsible for assuring that children who meet adult priority client criteria are integrated into the adult service system.

DMH is currently divided into seven major geographic Areas for the provision of services. In some Areas, however, boundaries are not co-terminous with those of the other child-serving agencies. A timetable for boundary realignment and establishment of common boundaries for the major EOHHS agencies will be announced this year, which will remove what has been a significant barrier to integrated service planning and delivery.

Interagency Coordination

GOAL IX/1: DEVELOP AN INTEGRATED SYSTEM OF CARE FOR CHILDREN SERVED BY PUBLIC AGENCIES.

Objective IX/1a-C: Continue working with other state agencies to implement initial steps of the plan approved by EOHHS which is expected to lead toward an integrated system of care.

Indicator: An operational plan for initial implementation of a unified case management system is collaboratively developed and submitted to the Secretary of EOHHS.

Indicator: A timetable for creation of common boundaries across the EOHHS child-serving agencies is announced by EOHHS.

Indicator: Mechanisms for pooling funds for service delivery to children are proposed by the child-serving agencies to the Secretary of EOHHS.

Indicator: Work is initiated under the aegis of EOHHS for creation of a cross-agency information and referral system.

Indicator: A plan is proposed by DSS, DMA and DMH for the common intake, assessment and triage of children with mental health problems.

Indicator: A plan is developed by DSS, DMH and DMA for a common system of utilization management of residential placements.

REQUIREMENT #X: The State plan shall describe the manner in which mental health services will be provided to individuals with a serious mental illness or emotional disturbance residing in rural areas.

The Massachusetts Department of Mental Health does not have an official definition of "rural" or a separate division or special policies for adults, children or adolescents who reside in rural areas of the state.

According to the 1990 census, Massachusetts has a population of 6,016,425, an average of 767.6 people per square mile. Although there are some towns in the western, central and southeastern (Cape Cod and offshore islands) parts of the state that are not attached to a Metropolitan Statistical Area, more than 75% of the population in the DMH Western and Central Mass. Areas is attached to identified urban centers.

The primary goal of the CCSS planning process is to address the issue of access to services for all DMH consumers, regardless of area of residence. Each of the 33 natural service areas established during the CCSS planning process has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the natural service areas has a population density below 100 people per square mile.

The individual CCSS plans submitted last year used an extensive statewide needs assessment (for adults) as well as utilization data and the participation of staff, consumers, family members, providers, and others, to identify target population, needs, available services, available resources, gaps in services and resources, and barriers to implementation of a comprehensive community support system. The plans are being refined this year to assure that budget planning and system design are based on solid data and realistic goals. The particular focus relevant to rural populations being addressed in the plans this year is access to transportation.

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

Access to Services

GOAL X/1: INCREASE ACCESS TO SERVICES FOR PERSONS IN RURAL AREAS.

SHARED OBJECTIVES

Objective X/1a-S: Develop strategies to improve transportation availability for persons living in rural areas and reflect this strategy in CCSS plans.

Indicator: The transportation needs of persons served in rural areas are addressed and plans or strategies are presented by the Areas in their revised CCSS plans for this fiscal year.

REQUIREMENT #XI: The State plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.

The Department published Prevalence Estimates for Long Term or Seriously Mentally Ill Adults, developed through a Task Force and supported by a NIMH Technical Assistance grant, in 1990. In 1993, these estimates were updated using 1990 federal census data. When the Center for Mental Health Services recommendations for a national methodology for estimating prevalence become available, DMH will revise its estimates to be consistent with the federal recommendations.

A special problem exists with respect to child/adolescent prevalence estimates. There is not at present a national research data base to support empirically derived estimates of the numbers of children and adolescents with serious emotional disturbances. The Department currently uses estimates based on studies conducted in North Carolina and Florida.

The following chart summarizes the prevalence estimates used by the Department.

Prevalence Estimates for Priority Clients

	Adults with Diagnosable Mental Illness w/Dysfunction (5.34%)	Adults with Severe Mental Illness & Severe Dysfunction (0.98%)	Children and Adolescents (5%)
Western Mass	38,676	6,815	5,115
Central Mass	28,199	5,147	4,011
Metro West	18,419	3,609	2,404
Northeast	48,361	8,864	6,412
Metro Boston	49,157	8,838	8,585
Metro South	18,249	3,600	2,390
Southeast Mass	42,682	7,858	6,624
Statewide	243,742	44,730	35,540

In the Plan, goals and/or objectives that are ***shared*** by both the Adult and Child/Adolescent systems will be listed only once and coded as (S) to indicate their *shared* applicability; goals and objectives relevant to only one of the systems will be coded as (A) for adults or (C) for children and adolescents.

GOAL XI/1: USE NATIONAL AND STATEWIDE DATA TO ESTIMATE THE NUMBERS OF ADULTS AND CHILDREN, INCLUDING THOSE WITH UNIQUE NEEDS, IN EACH DMH AREA, WHO REQUIRE PUBLICLY FUNDED SERVICES.

SHARED OBJECTIVE

Objective XI/1a-S: **As national prevalence methodology and standards are developed and promulgated by the Center for Mental Health Services, adjust the Massachusetts procedures for estimating prevalence as appropriate.**

Indicator: A revised Adult Prevalence Estimate Report is distributed within three months of the promulgation of a national methodology.

CHILD ONLY OBJECTIVE

Objective XI/1b-C: **As national data and methodologies are developed and become available for use by states, develop and promulgate child/adolescent Prevalence Estimates that reflect current expert thinking and established empirical data.**

Indicator: Child/Adolescent Prevalence Estimates are published for internal review and analysis.

Indicator: Child/Adolescent Prevalence Estimates are revised when new methodologies are developed.

REQUIREMENT #XII: The State plan shall contain a description of the manner in which the State intends to expend the grant for the fiscal year involved to carry out the provisions of the plan in the foregoing requirements (I - XI).

The tables that follow indicate specifically how Block Grant funds are used to support program goals and objectives detailed in the preceding Requirements I - XI. The tables show the specific services that are funded in

accordance with these Requirements. The 1995 State Plan pertains to the mental health service system as a whole and includes goals that are expected to be carried out with state and private funds in addition to federal funds.

Table One indicates the services to be purchased assuming a $6.354M allocation of Block Grant funds in accord with federal requirements that include funding for child and adolescent services. The Massachusetts Department of Mental Health has allocated $1,905,168 in the FFY'95 Block Grant for child/adolescent services. (These numbers will be adjusted when Massachusetts receives final notification of the FFY'95 grant amount.) The state has already complied, as indicated in the FFY'93 and FFY'94 Block Grant applications, with the allocation set-aside for children and adolescents. In addition, under the maintenance of effort, the state ensures that relative to state expenditures, the level of services allocated for children and adolescents will be maintained. It should be noted that $2.5M previously transferred from the substance abuse Block Grant and included in Block Grant funding for mental health services in FFY'93 and FFY'94 is no longer available. The provision for this transfer expired at the end of FFY'94. It should also be noted that reduced federal funding for the Block Grant and a recalculation of the distribution formula have resulted in a smaller grant for FFY'95.

Table Two indicates the service delivery areas involved assuming a $6.354M allocation, to the extent that information is available at the current time. For example, the specific allocation by vendor and Area of some of the funds has not yet been determined. Proposals and contracts for these funds and services will be developed in anticipation of the awarding of the grant and is based on an estimated level of funding.

The **administrative** component of the Block Grant is used to perform administrative and accountability functions such as development of prevalence estimates and mechanisms for monitoring program accountability and expenditures of Block Grant funds.

FFY95 PROJECTED BLOCK GRANT SPENDING PLAN

TABLE ONE

Description	FFY95 %	Projected FFY95 Funding
Office Administration	0.82%	52,178
Program Support	0.49%	31,452
Research	2.26%	143,292
Subtotal Administration	3.57%	226,922
Skills Training	6.60%	419,469
Supported Employment	1.35%	85,961
Specialized Residential	0.96%	61,133
Out Patient	0.82%	52,306
Psychiatric Day Treatment	5.41%	343,717
Consumer/Family Support	0.35%	22,550
Community Support	11.65%	740,074
Individual Support	0.36%	22,787
Subtotal Adult Services	27.51%	1,747,997
Home Based Treat & Crisis Intv	17.10%	1,086,770
OutPatient Services	2.62%	166,294
Comm &School Therap Support	4.74%	301,426
Flex Individual Support Non Res	1.05%	67,007
Crisis Respite/Therapeutic Foster Care	4.46%	283,671
Subtotal Children's Services	29.98%	1,905,168
Crisis Intervention	37.18%	2,362,555
Forensic Evaluation	1.75%	111,512
Subtotal Mixed Services	38.94%	2,474,067
Total Services	100.00%	6,354,154

TABLE TWO
FFY95 BLOCK GRANT SPENDING PLAN
COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS

WESTERN MASS AREA
James Duffy, Ph. D., Area Director
P.O. Box 389
Northampton, MA 01061
(413) 784-1790 Total FFY95 Allocation: $67,007

CENTRAL MASS AREA
Constance Doto, Area Director
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604
(508) 752-4681 Total FFY95 Allocation: $953,925

NORTHEAST AREA
Lorene Bourque, Interim Area Director
P.O. Box 387
Tewksbury, MA 01876
(508) 851-7321 Total FFY95 Allocation: $2,507,061

METRO WEST AREA
Theodore Kirousis, Area Director
Westborough State Hospital
P.O. Box 288 Lyman Street
Westborough, MA 01581
(508) 792-7400, x207 Total FFY95 Allocation: $401,826

METRO BOSTON AREA
Clifford Robinson, Area Director
20 Vining Street
Boston, MA 02115
(617) 727-4923 Total FFY95 Allocation: $981,861

METRO SOUTH AREA
Barbara Leadholm, Area Director
Medfield State Hospital
45 Hospital Road
Medfield, MA 02052
(508) 369-7312 x600 Total FFY95 Allocation: $397,657

SOUTHEASTERN AREA
John P. Sullivan, Ph. D., Area Director
Brockton Multi-Service Center
165 Quincy Street
Brockton, MA 02402
(617) 727-0827 Total FFY95 Allocation: $551,843

STATEWIDE INITIATIVES
Valerie Fletcher, Deputy Commissioner for Program Operations
Central Office
25 Staniford Street
Boston, MA 02114
(617) 727-5500 x402 Total FFY95 Allocation: $492,974

TOTAL: **$6,354,154**

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health

STATEWIDE ADVISORY COUNCIL
State Mental Health Planning Council

September 30, 1994

Eileen Elias, Commissioner
Department of Mental Health
25 Staniford Street
Boston, MA. 02114

Dear Commissioner Elias:

The Mental Health Planning Council, a sub-committee of the Statewide Advisory Council, met on September 29, 1994 to review the 1995 State Plan. On behalf of the Council, I am writing to provide you the Council's reactions and comments.

At the outset, it should be noted that for a variety of reasons the Center for Mental Health Services was unable to provide complete and specific information relative to the amount of the block grant for FY 1995, and only recently issued the plan guidelines. As a result, Council members did not have the amount of time to review the plan which it has had in previous years. Nevertheless, copies of the draft plan were provided to the members, and, notwithstanding the condensed time frames, we have seen changes made as a direct result of the comments made by members to the Department. We continue to be impressed with the Department's efforts and resolve to solicit the views of the Council, and to respond in a positive fashion to both our requests for information, and those areas where we have expressed some concerns. For this we are grateful.

It should also be noted that, without exception, the members of the Council support the Department's efforts to increase the amount of the block grant from the currently announced level of $6.3 Million to $7.3 Million. While we understand that the block grant represents a small percentage of the entire funding level of the Department,

the needs of the consumers and their families warrant the effort to obtain the additional one million dollars. We stand with the Department in that attempt.

Council members have expressed concern about the provider network, quality and access to care provided through Mental Health Management of America (MHMA), Medicaid's mental health and substance abuse vendor. While we are aware that the Department is virtually "out of the business" of providing acute in-patient care to children and adolescents, it must continue to vigorously advocate, monitor and evaluate the care being provided through MHMA and insurance carriers. Accountability to the Department, and through it, to consumers, is a paramount concern to consumers, their families, and the Council.

A related and equally important issue is the realization that as in-patient care days are reduced and the movement towards integrated community care continues and increases, we must remain fully aware of the additional stress and responsibilities this places on consumers and their families. Family members often become "quasi" case managers, care attendants, and providers of support services for the consumer. These family members, in turn, need support services to assist them in their new roles. If family support is not provided, the savings resulting from reduced in-patient treatment will be quickly absorbed by the costs to society associated with increased family stress, divorce, unemployment, and similar consequences.

We need to understand as well that consumers coming into community programs following a reduced in-patient stay, often need stronger support services than they otherwise would have required if the in-patient treatment had been a week or two longer. In short, we need to continue the effort to ensure that the savings realized by managed care are used to provide the kinds of support services consumers and family members require to survive and prosper. The services needed should be the services provided.

We received written comments on the plan which expressed the view that while the Department and the Plan are to be commended for the emphasis placed on vendor training programs and quality improvement activities, we should recognize that these do place additional burdens on the line staff of small vendors. Many, if not all, have gone without increases, and this adds to the difficulties encountered by those who wish to attend the sessions and to participate in these activities.

Council members also expressed the view that services for the elderly consumer should be separately categorized and not simply indicated as part of and included within services for the adult population. While we understand and

support the Department's efforts and programs targeted for this population, consideration should be given to developing a budgetary format which characterizes Department services as (1) Children and Adolescents; (2) Adult; and (3) Senior Community.

In the area of DMH's contracting with private facilities to provide in-patient services, the Council applauds the Department for agreeing to include as a State Plan indicator that it will monitor these facilities for compliance with human rights. We urge, however, that the Department consider more specific language concerning the applicability of DMH's human rights regulations to these private facilities. In addition, we suggest that the contracts guarantee access to patients by those agencies whose mission it is to protect the human rights of consumers - such the Center for Public Representation and the Mental Health Legal Advisors Committee. The Council appreciates the complexity of this issue, as well as the fact jurisdiction over this issue may not rest exclusively with the Department. We do, however, urge continued work and progress in this area. The human rights of consumer patients which the Department and the Council clearly recognize can become empty if meaningful access to legal advocates is denied or unreasonably restricted simply because the care is being provided in a private facility.

The Council was also provided copies of projected block grant spending plans at both the $6.3 and $7.3 Million levels. We understand they were developed not at Central Office, but rather through the Comprehensive Community Support Services (CCSS) planning process. We continue our support for the CCSS Process and appreciate all the work and effort you and the Department have extended in this area.

The spending plans did raise what is commonly referred to as the "Western Massachusetts Equity Issue." Simply stated, the issue is as follows: Block grant funds are not spent on hospital care, but rather for community support programs. Western Massachusetts receives a smaller allocation from the block grant because the funding needs of its community support system appear less pressing than other areas of the Commonwealth. However, as asserted by council members from that area, the less pressing need is because the area addressed its hospital issues and shifted care to community support programs. They should not, they argue, be punished for doing that which other areas have been slower or less aggressive in doing.

Representatives from the Department were available to point out to the Council that when one considers the funding Western Massachusetts receives from the State funded portion of the Budget, along with the block grant funds, the apparent disparity is greatly reduced.

As previously expressed, the Council supports CCSS Planning, as well as the equity considerations the Department has placed into that process. We should, however, remain mindful of the point being raised by Western Massachusetts. That is, the availability of block grant funds for community based programs should not be used as an incentive for a less than aggressive approach towards moving institutional dollars to community based programs and support. Otherwise, you punish those areas which have improved community support by addressing hospital costs, and reward those who need community support funds because they perhaps have been less aggressive.

With respect to the Western Massachusetts area, concern was also expressed that unresolved rate issues at the Bershire County Medical Center were creating barriers for DMH consumers.

In closing, the Council is grateful for the welcomed responses it continues to receive from the Department to issues and concerns our members raise. The commitment to consumer empowerment, and their involvement in development of DMH policy is one we share with the Department. We look forward to our continued participation in Department policy development and in the implementation of the 1995 State plan.

Sincerely,

Bernard J. Carey, Jr.
Co-chair
Mental Health Planning Council